Maternal and Child Health Services
Title V Block Grant

State Narrative for MONTANA

Application for 2007
Annual Report for 2005

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Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

The State of Montana maintains on file in its Fiscal Division all the assurance required by this application for Maternal an Child Health Block Grant. On file in agency rules are prohibitions of necessary items. The agency assures the MCHBG that the funds will be used for non-contruction programs, that debarment and suspension remain in place as in previous years, that the agency is a drug free work place and tobacco free. The agency has on file all necessary paperwork for lobbying state legislature and the prevention of fraudulent use of fund.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

Public input is solicited through local public health departments in the form of pre-contract surveys. Counties are also required to include consumer surveys in their contract responsibilities, to further inform them regarding the impact of MCH programs. Administrative Rules of Montana requires counties to conduct periodic needs assessments, which are reported via the pre-contract surveys.

Public input is also obtained from the Family and Community Health Bureau (FCHB) Advisory Council members, who represent various MCH partners and constituents. Updates on the needs assessment process were provided to the FCHB AC at each meeting during the last year, and the needs assessment and the priorities were sent to the AC for review and comment prior to finalizing. Advisory Council members will be invited invited to participate in the video link to the block grant review. A report on review findings is scheduled for August, and a copy of the final reviews are sent to the AC following receipt.

Copies of the block grant are made available to Advisory Council members, and availability of the text and data and updates on the block grant are provided through the FCHB Facts newsletter. The newsletter is distributed electronically every other month, and has a distribution of approximately 180 (in department) and 100 (out of department). A copy of a recent FCHB Facts newsletter is attached.

/2007/ The public input process is unchanged from 2006. A proposal has been made that the FCHB Advisory Council members be governor-appointed (attached). A link to the MCHBG application and narrative will be added to the FCHB website. //2007//
An attachment is included in this section.

II. Needs Assessment

In application year 2007, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

III. State Overview

A. Overview

Montana's geography, population size and distribution, nature of her minority groups, political jurisdictions, and economic characteristics have a profound effect on: the health of her citizens; how direct and public health services are provided; and on the enormity of health disparities in the state. These factors affect both the State's health priorities and initiatives, and the process for determining those priorities.

GEOGRAPHY: Montana is the fourth largest state in the United States, encompassing 145,552 square miles, 56 counties, and seven Native American reservations. Western Montana is mountainous, heavily forested, dotted with waterways, and state parks and state forests. The eastern two-thirds of the state is semi-arid to arid and access to water is often a concern. Annual precipitation averages less than 15 inches. Forest and range fires routinely affect local air quality and can exacerbate asthma and other respiratory conditions.

Vast distances, isolation of small communities, sparsely located ranches and farms, as well as severe winter weather can make travel extremely difficult and often dangerous, especially over icy mountain passes or through ground blizzards on the plains. Public transportation is limited, with many areas in the state totally devoid of air, rail, or bus transportation. The Insurance Institute for Highway Safety published a study of traffic safety laws in all 50 states in June 2005. The laws they rated were seat belt use, young driver licensing, DUI, child restraint use, motorcycle helmet use, and red light camera laws. Montana had the poorest ratings for motorcycle helmet use and red light camera laws, with only marginal ratings for young driver licensing, safety belt use, and child restraint use. Montana was the third highest state for motor vehicle deaths per 100,000 people in 2003, accounting for 262 deaths. For 2004, Montana ranked 50th in the nation for motor vehicle fatalities with 2.5 deaths per 100,000,000 miles driven.

POPULATION CHARACTERISTICS: U.S. Census reports the 2000 population was 902,195, 44th in terms of population, with a population density of 6.2 people per square mile. The 2004 population estimates for Montana suggest an overall increase of 2.7% from 2000, with the in-state population redistributing to the western portion of the state and into urban areas. Montana has three metropolitan areas and five areas with a population over 10,000 people. Sixty-four percent of Montanans reside in these eight areas, with the remainder of the population dispersed into smaller communities, farms, and ranches. In 2000, Montana had 0.3% of the total population of the United States, with little change projected by the census for 2004. It is projected that Montana will have an 11% increase in population from 2001 through 2015, 28th in population growth for the time interval. Projected population for 2030 is 1,044,898, ranking 27th in the nation for population growth.

The median age in Montana for 2000 was 37.5 years, higher than the national average of 35.3 years. Projections for 2030 suggest Montana's median age will increase to 46.0 years, representing a 22.7% increase in median age for the state. Montanans over 62 years of age are predicted to increase 115.6% by the year 2030, with a 0.4% decrease in children less than 18 years of age. Montana's population is split evenly between males and females. In 2000, the median age for men was 36.6 and for women was 38.5. Women of reproductive age (15-44 years) comprised 20.5% of the state population, and children and youth under 20 represented 28.5% of the population.

In 2002-2003, Montana pupils scored at or above proficiency for math, science, and reading assessments. Montana ranked 28th in math proficiency and 9th in reading proficiency, according to CFED for 2004. Montanans also tested slightly higher than the national average on the ACT, with 81% of graduating seniors taking the test. For 2003-2004, Montana had a high school diploma rate of 82.9% and a high school completion rate of 84.8%. Historically, Montana's pupil teacher ratio has been significantly smaller at 14.5 pupils per teacher than the U.S. average

of 15.9. IEP percentages (learning disabilities) were slightly higher than the national average during the time interval. For 2003-2004, Montana ranked 47th in teacher salaries ($37,184), and state budget allocations for education were significantly lower than the national average (12% difference). People in Montana 25 years old and over with a bachelor's degree or more in 2003 accounted for 24.9% of the population, ranking 27th in the nation. Estimates for 2004 suggest a 2.4% increase from 2003. Montana's university system comprises of two universities, four colleges, and five colleges of technology. In addition, there are six private colleges, seven tribal colleges, and three community colleges. Montana ranked 22nd in the nation for computer and internet presence in the home.

In 2002, Montana ranked 34th in total crime per 10,000, 29th in violent crimes, and 24th in the juvenile crime index. In 2002, Montana ranked 31st in percent of births to unwed mothers. There were approximately 13.6 TANF recipients per 1,000 population in April 2005, 87.7 food stamp recipients per 1,000 population, with the average amount of food stamps per household equal to $215.44. Both the number of cases and the average amount per case has increased steadily since 2000, according to DPHHS.

Montana is predominately white with approximately 91% of the 2000 population reporting Caucasian as the primary race, compared to 75% in the nation. Eleven American Indian tribes make up the largest minority population in Montana, representing approximately 6.2% of the total population (56,068), the 5th highest state in the nation. Estimates for 2003 suggest a 4.8% increase from 2000, with American Indian births accounting for approximately 12.2% of the births in the state. The number of people of Hispanic origin has been growing faster than other minority groups with the exception of Native Americans, demonstrating a 5% increase from 2000 to 2003 (estimate). Minority groups that may not be captured by census data, but that may have unique health issues, include migrant and seasonal farm workers and religious groups such as the Hutterites. There are also isolated pockets of other minority groups including a Southeast Asian cluster of about 200 to 300 persons in western Montana as well as about 300 Russians.

2000 Census Population Demographics

White	90.6%	Asian	0.5%
American Indian	6.2%	Black	0.1%
Hispanic	2.0%	Other	0.7%

ECONOMIC CHARACTERISTICS: Montana's economic history is one of extraction of natural resources. Currently, the majority of the land is used for agriculture and the production of oil, gas, lumber, and coal. Limited mining for copper, silver, palladium/platinum, and gold continues. However, these extraction processes have left a legacy of environmental pollution. In 2004-2005, Montana had 15 Federal Super Fund sites and 208 CERCA priority facilities. The vermiculite mines in Libby, Montana were shut down in 1990. A medical screening program conducted by the Agency for Toxic Substances and Diseases Registry (ATSDR) and the State of Montana DPHHS has disclosed that several hundred people were exposed to asbestos contaminating the vermiculite and have evidence of asbestos-related diseases. According to the EPA in 2005, small sources of vermiculite are still found in a variety of places in and around people's homes and businesses. However, air monitoring indicates it is safe to walk the streets of Libby. DPHHS Environmental Public Health Tracking was established in 2004 with support from a 3-year grant from the CDC. EPHT's vision is to better protect communities from adverse health effects through the integration of public health and environmental information, such as the Libby, Montana exposure. EPHT will improve surveillance of chronic diseases, birth defects, and developmental delays, and link health data with existing data on environmental hazards and exposures, to better inform the public regarding health concerns.

Montana also ranked 50th for employment wages, with the average annual pay equal to $26,001 for 2002 and 2003 estimates increasing only 3.3%. In 2001, at least 9.3% of employed individuals in Montana held more than one job. In December, 2004, the top five employment industries in the state were government, trade, transportation and utilities, education and health

services, leisure and hospitality, and professional and business services. Tourism is becoming a major industry -- non-state residents spent $2.7 billion in the state in 2002. Approximately 9.8 million visitors generated 43,300 Montana jobs. However, tourism jobs are typically in the service sector, which pays relatively low wages for the majority of jobs.

Federal aid to state and local governments per capita for 2003 ranked Montana 12th in the nation. Federal funds accounted for 62 cents of every dollar of state revenues spent. Resources supporting state level efforts for MCH and CSHCN are overwhelmingly federal -- less than 5% of funding for the FCH Bureau or the CSHS section is from the state general fund. Montana depends on its local partners to make up the required match for the MCHBG. Data for 2002 suggests Montana had $6,973,894 in federal funds and grants.

POVERTY: Montana is ranked 11th in the country for percent of the population below poverty level for 2000-2002. According to 2002 Census estimates, 25.5% of children under five and 16.7% of children ages five to 17 live in poverty. Overall, 14.0% of Montana's population lives in poverty, while the national average for 2000-2002 was 11.7%. Preliminary 2003-2004 data suggests Montana has 20.2% of it's children living in poverty, ranking the state 42nd in the nation. Five out of seven reservations are found in eastern Montana, an area with limited natural resources, high unemployment, and disproportionate poverty.Since 2001, Montana's unemployement rate has been lower than the U.S. According to the U.S. Department of Labor, Montana's unemployment rate in 2004 was 4.4%, compared to the U.S. rate of 5.5%. However, unemployment for the tribes ranged from 40.58% to 77.21%, with an average unemployment rate of 59.63% for 2001 Montana Progressive Labor Caucus data. Reservation data collected by Montana DLI suggests lower unemployment rates may exist. Year after year, data on poverty in Montana continues to demonstrate disparities between the population as a whole compared with the seven Indian Reservations.

Annual Average Unemployment Rates on Montana's Reservations

Reservations	2001	% Employed but below poverty	Tribes 2001
Blackfeet	70.0%	26.0%	69.93%
Crow	66.0%	16.0%	60.65%
Flathead	76.0%	22.0%	40.58%
Fort Belknap	71.0%	20.0%	70.49%
Fort Peck	63.0%	23.0%	62.54%
Northern Cheyenne	27.0%	7.0%	64.69%
Rocky Boy's	36.0%	37.0%	77.21%
Reservations Total	59.86%	NA	59.63%

In 2004, Montana ranked 20th in bankruptcy filings by individuals and businesses. Homeownership rates for 2004 data suggest 71.5% of Montanans own their home, ranking 23rd in the nation.

POLITICAL JURISDICTIONS: The state has 46 frontier counties, 8 rural counties, and only 2 urban counties. Fifty-four county health departments contract with the DPHHS to provide MCH and other health services, but the local health departments are county entities under the control of local Boards of Health, and the staff are county employees. The seven Indian reservations have nation status for 11 American Indian tribes occupying 8.4 million acres. This status, coupled with the federal role in public health on the reservations, pose jurisdictional challenges affecting coordination of county and tribal health services for common clients between the two service delivery systems. The other three tribal health clinics belong to the three "compact" tribes that staff their own clinics. Although the I.H.S. data system is used at all seven tribal health clinics, patient health data that is not entered into the system for I.H.S. staff services may not be shared with the State without separate agreements with the three compact tribes. According to the Tax Foundation, the federal tax burden on Montana is 17.5% for 2005, ranking Montana 35th in the

nation. The state and local tax burden is 9.5% for 2005, ranking the state 39th in the nation. New tax relief measures implemented in 2005, including a 10% tax bracket, child tax credits, reduction of income tax rates, and reduction of the marriage penalty, will provide benefits to thousands of taxpayers and businesses. Child tax credits, reduction of income tax rates, reduction of the marriage penalty, and other changes to the tax laws will benefit many Montanans.

ACCESS TO HEALTH CARE: Nine counties have no private medical services at all. There are 54 local county public health departments. Health care for the tribal residents of Montana is provided by a network of services including: off-reservation hospitals; clinics and practitioners; county health departments; Indian Health Service systems; and tribal health services. There are three urban Indian full-service medical clinics located in Billings, Great Falls, and Helena and two referral based clinics in Missoula and Butte. Montana ranked 15th in the nation for the percent of health dollars for public health, 19th in per capita public health spending, and 36th in adequacy of prenatal care. Montana has 21 local hospitals, 40 Critical Access Hospitals (CAHs), and 20 Community Health Centers. All hospitals provide access to care for low-income, indigent, Medicaid, and Medicare patients. There are two hospitals that provide pediatric mental health care, five provide care exclusively for veterans and American Indians and are federally owned and operated. All but the hospitals in Billings and Great Falls are classified as rural facilities by HCFA. Sixty percent of primary care physicians are located in Silver Bow, Yellowstone, Missoula, Gallatin, Cascade, Lewis and Clark, and Flathead counties, the seven most populated counties in Montana. Establishment of Rural Health Clinics (RHC), under the provisions of PL. 95-210, has improved access to health care in many counties and communities. There are 40 Rural Health Clinics in Montana and several additional sites are currently considering conversion/establishment of a RHC. There is one Migrant Health Center (MHC) in Montana located administratively in Billings. Satellite services have been provided over the last several years in six locations.

According to 2004 CFES data, Montana ranked 50th in the nation for employer-provided insurance. Low-income children and low-income parents consisted of 19.8% and 82.3% of the population for 2004, respectively. CFES gave Montana an "F" in health care for these reasons. The Bureau of Business and Economic Research of the University of Montana is studying the incidence of uninsured status in Montana and on June 25, 2003, reported the following for the Montana population under age 65: 43% of urban and 57% of rural residents are uninsured; 31% to 45% of American Indian residents are uninsured, while 18%-22% of Whites and all others lack health insurance. Most of the businesses in Montana are small businesses and cannot afford health insurance premiums for their employees. Agricultural families are often disqualified from public programs because of high assets, even with low income, and cannot pool for reduced premiums.

Oral health care had become a major public health issue. The Montana Foundation of Dentistry for the Handicapped provides free comprehensive dental care to people who are permanently disabled, medically compromised or elderly, and who cannot afford dental care. Six Montana Community Health Centers (Billings, Butte, Great Falls, Helena, Missoula and Libby) include some dental services, though the waiting lists can be long. Dental clinics are offered in thirteen locations through the Indian Health Service. Montana's point-in-time PRAMS in 2002 reiterated lack of access to dental care for pregnant Medicaid participants was a statewide problem. Data for 2004 suggests Medicaid-payable dentists are also a resource problem, with 14 counties lacking at least one Medicaid-payable dentist and 14 counties with only one Medicaid-payable dentist, representing 50% of all Montana counties. Oral health results from a statewide convenience sample of third graders for 2002-2004 suggested immediate caries were a problem for 25.1% of the sample, with a past caries rate of 50.7%, and an urgent caries rate of 6.2%.

High mortality rates are a large problem for Montana. Montana ranks 46th in the nation for occupational fatalities, with 12.3 deaths per 100,000 workers for 2004. Cardiovascular deaths for 2004 equaled 296.2 per 100,000 people, ranking 11th in the nation. Cancer deaths in Montana

ranked 23rd in the nation, infant mortality 27th in the nation, premature death 22nd in the nation, and total mortality 32nd in the nation. Leading causes of death in Montana are heart disease, cancer, cardiovascular disease, diabetes, pneumonia, chronic obstructive pulmonary disease, and accidental deaths due to unintentional injuries. For Montana Indians, accidents, diabetes, and chronic liver disease and cirrhosis follow heart disease and cancer for the leading causes of death. Whites typically die at an older age than Indians. (Montana Bureau of Records and Statistics, 2003) Montana is 2nd in the nation for death rate by suicide, at 19.3 per 100,000 population in 2001.

Drug abuse in Montana is a growing concern, especially methamphetamine use. The U.S. Drug Enforcement Administration reported 2003 federal drug seizures in Montana included 0.5 kg cocaine, 107.2 marijuana, and 8.8 kg of methamphetamine. In 2002, Montana law enforcement agencies responded to 122 meth labs statewide. BRFSS for 2003 reported 9.3% of students grades nine to 12 reported using meth at least once in their lives. The Billings area has an active methamphetamine task force while other communities scramble to become informed about the implications of meth use and the potential impact on the maternal and child populations in their areas.

Domestic violence continues to grow in scope. Statistics for 2001 suggest 7.0% of aggravated assaults were by a spouse or ex-spouse and 6.5% were from boyfriends or girlfriends. PRAMS data for 2002 suggests 8.8% of all Montana women aged 15-45 are abused before pregnancy and 5.0% during pregnancy. However, the Montana Board of Crime Control suggests reported domestic violence to be only 0.45% of the population-at-risk for abuse, suggesting underreporting is a serious issue in Montana.

CDC's State Health Profile for Montana notes childhood health concerns include birth defects, vaccination coverage, infant mortality, prenatal care, and teen pregnancy. Montana has developed a birth defects registry that now contains data for 2000 through 2004. A heightened rate of Downs Syndrome appears in the data, along with other defects of concern including gastroschisis, diaphragmatic hernia, and cardiovascular defects. The Fetal Infant Child Mortality Review (FICMR) program, authorized by the Montana State Legislature in 1997, has published two reports since its inception. There were 1,256 fetal, infant, and child deaths in Montana from 1997-2002, accounting for 1.0% of the cumulative birth cohort (N=130,694). Cumulative review percentages suggest 59.2% of all fetal, infant, and child deaths were reviewed by the 27 local FICMR teams covering 48% of the counties. Nevertheless, the program determined that 39.7% of the cumulative reviewed deaths that contained prevention findings were preventable.

Montana continues to face a health care worker shortage. During the reporting years 2001 to 2002, a task force was created and appointed by the Governor "to accurately assess the shortage of health care workers, and to develop recommendations and strategies to effectively address the issue." As of 2002, there were 2.0 physicians per 1,000 population, as compared to the U.S. average of 2.3 physicians per 1,000 population, according to the Northwest Area Foundation. This statistic ranks Montana approximately 34th in the nation. For the year 2012, DLI predicts only 2,077 physicians and surgeons for Montana, a rate of 2.1 physicians per 100,000 population, based on a 984,043 population projection. Dieticians and nutritionists are projected to reach 216, a rate of 2.2 per 100,000 population. Registered nurses are projected to reach 10,707, a rate of 10.9 per 10,000 population. However, even with all the known shortages, Montana's response has only been to establish a task force commission or panel, which is 1 out of 7 measurable responses.

In 2002, Montana ranked 44th and 47th in the nation for series of immunizations given to 19-35 month old children. In 2003, Montana ranked 24th in infant mortality at 6.8/1000 live births. Three-year cumulative average for people without health insurance coverage was 16.1% for 2001-2003. In 2002, Montana estimates indicated 54% of the adult population to be overweight or obese. The same dataset estimated the adult smoking prevalence rate to be 19.9% of the population. Smoking-attributable direct medical expenditures (state share) are estimated at $216

million. There are approximately 1,439 annual smoking-attributable deaths in Montana, according to the Center for Tobacco Cessation. Montana is 1st in the nation for adolescent male use of smokeless tobacco. In 2000, Montana ranked 35th in Medicaid recipients and 25th in state and local funding spent on health and hospitals. Montana ranked 34th in per capita spending on Medicaid recipients, 7th in average Medicaid spending per child, and 19th in Medicaid spending on aged recipients. Montana ranked 6th in the nation for hospital expenses per inpatient day at $2,573. In 2003, Montana had 47,088 enrollees in HMOs in 2003, down from 2002.

This snapshot does not tell the whole story. Montana needs nearly 1,000 more health care workers right now just to catch up to the national averages! And, as Montana's population continues to age, demand for all occupations - including those that are now adequately staffed - will rise dramatically while the health care workforce diminishes. The impact will be felt more dramatically in Montana than in most other states because of our older-than-average population

/2007/

POPULATION CHARACTERISTICS: The 2005 population estimate for Montana is 935,670, constituting a 3.7 increase from April 2000 to July 2005 http://www.census.gov/hhes/www/poverty/poverty04/stategrid.xls .

POVERTY: Census figures for 2002-2004 indicate the percent of Montana's population living in poverty is up to 14.3% http: www.census.gov/hhes/www/poverty/poverty04/stategrid.xls

ACCESS TO HEALTH CARE: Montana has eleven Community Health Centers, with seven satellite sites, one Migrant Health Center with nine satellite sites, and one Healthcare for the Homeless Program with three satellite sites. Four additional communities have submitted Community Health Center applications. Oral health services are available at eight of the centers and through two mobile clinics. http://www.mtpca.org/mtcenters.htm //2007//

B. Agency Capacity

The Title V programs are located within the Health Resources and Public Health and Safety Divisions of the Department of Public Health and Human Services. The structure of DPHHS is described in the organizational structure section of this application. Title V efforts are primarily focused in the Family and Community Health Bureau of the Public Health and Safety Division (PHSD) and in the Children's Special Health Services (CSHS) program, which is located in the Health Care Resources Bureau of the Health Resource Division.

The Family and Community Health Bureau (FCHB) is the primary MCH agency, responsible for development of the MCHBG report and plan, budget monitoring, and implementation of the plan. The Family and Community Health Bureau has a staff of approximately 30, and a budget of approximately $21 million, from 13 funding sources including grants from CDC, HRSA, SAMHSA, USDA, the Office of Population Affairs, and Montana general fund. The largest program and budget is the WIC Program, with a budget of approximately $14 million. The MCHBG is the second largest funding source, at about $2.5 million annually. Approximately 95% of the FCHB budget is federal dollars.

Local providers are crucial partners in the provision of MCH services in Montana. Approximately 42% of the MCHBG is contracted out to local health departments to provide MCH services to the population. Of the $1.1 million of state level match, 1/2 of that is also contracted to local health departments for public health home visiting services to pregnant women and infants. The remaining $500,000+ is contracted to for genetics services for the MCH population.

FCHB is also responsible for coordinating the MCH needs assessment and subsequent further prioritization of MCH needs and strategic planning that will take place in 2005 and 2006.

The Children's Special Health Services (CSHS) program in the Health Care Resources Bureau administers 30% of the MCHBG. HCRB provides services to children in three ways: direct services to children, indirect services to children, and administrative services.

Direct services to children include cleft cranio-facial clinics, metabolic clinics and case management services, regional clinics, nutrition services, neonatal follow-up, newborn screening follow-up, medical home program, transition services, case management, care coordination, clinic coordination, systems of care development, dental services, vision services, hearing aids, medical services, enrollment, and medical reviews.

Indirect services to children include: outreach, cultural competence, plan relations, provider relations, advocate liaison, enrollee education/newsletter, quality assurance/improvement, customer service, family support and referral, health care integration for access, coordination and referral, policy development and review, complaint processes, web page development and maintenance, and data systems development and coordination.

Administrative services include: office and facilities management, personnel management, labor-management relations, state/federal coordination, CHIP State Plan, MCH Block Grant submission, administrative rules, file and chart systems, research, professional development, surveys, technical assistance, contracts, waivers, payroll, new employee orientation, communication, budget and fiscal, performance measurement, grant writing, safety and security, program evaluation, legislative support, congressional requests, public relations, and purchasing and inventory.

Co-location of the CSHCN program with the CHIP program has facilitated coordination of applications for services for children between those two programs, Medicaid, and other programs, which may benefit children and their families. The HCRB Bureau manages the Family Health Line, which is the Title V toll free line, directing callers to programs within DPHHS and around the state. The Children's Mental Health Bureau is also located in the HR Division. That bureau is directing development of the Kid's Mental Health Services Areas or KMA's in the state, which may address and improve the mental health service needs of the MCH population.Services are provided to Montana children with special health care needs and their families by the CSHS program staff and their contractors.

Services include specialty clinic services, direct payment of medical services for eligible children who have no source of payment for needed care, identification and referral of children with special health care needs, and consultation and technical assistance. The number of children receiving direct pay services has decreased as insurance coverage becomes more available. In Montana, CSHCN program eligibility is based on diagnosis/condition and financial eligibility. Montana does not have a medical school or a school of public health, and relies on partnerships with private providers to develop and deliver services to the vulnerable populations. The CSHS has developed partnerships with two hospitals in Missoula and Billings for regional specialty clinic services, and is working towards development of a third regional clinic site in Great Falls. The Montana Legislature included a line item to support additional regional clinic development in the 2005 session. Program staff is developing the ability of clinics to bill for services, which will diversify funding available to support these sites, which have been primarily supported by hospital in-kind and MCHBG contract funds to date.

CSHS continues to foster relationships with non-profit organizations dedicated to children's issues. Parents Lets Unite for Kids (PLUK) is a longstanding advocate for parents and families, and the host organization for Montana's Family Voices chapter. Work with PLUK has centered on collaboration to improve access to community-based, family-centered services for CSHCN.

The Family and Community Health Bureau's mission is the "promote the health and well being of Montana's citizens to help healthy families build health communities." The bureau is organized into four sections: the MCH Data Monitoring (MCHDM) section, the Child, Adolescent and Community Health (CACH) Section, the Nutrition/WIC Section and the Women's and Men's Health Section. MCHBG funding and program efforts are primarily located in the MCHDM and CACH sections.

The MCHDM section manages the 54 local MCH services contracts, oversees the MCH block grant development and performance measure monitoring, and is responsible for the population based newborn metabolic and hearing screening programs. That section has also housed the Point in Time Pregnancy Risk Assessment Monitoring project from 2001 -- 2004; the state intends to apply for CDC funding to reinitiate the program in 2005. The MCHDM section also manages the state's genetics program and contract, which is funded with a tax on individual insurance policies. Legislative changes in 2005 resulted in an increase of that funding source, which will in turn result in a reassessment of contractor role and services.

The MCHDM section houses Montana's birth defects registry, the Montana Birth Outcome Monitoring System (MBOMS), which was initiated with CDC funding in 2000. The population-based registry identifies and refers children in need of services to the CSHCN and other appropriate services. Initially, the program was a passive case ascertainment system, focusing on four major anomalies - congenital hypothyroidism and cleft-craniofacial, cardiac, and neural tube defects. CDC recommended active case ascertainment, which was added in 2001. The program was funded for an additional three years of CDC funding in 2002. A renewal application submitted in early 2005 was reviewed, approved, but not funded, leaving the future of the registry in question. At present, the registry, including the active case ascertainment will be continued with carry over dollars, supplemented as possible with MCHBG. The long-range feasibility of continuing this support continues to be in question, especially in view of the MCHBG decreases over the last several years. Birth defect monitoring efforts continue with grant carryover and MCHBG funding at this time -- partnerships with the state's Environmental Public Health Tracking program are being explored. The registry has helped identify and inform investigations of what appeared to be high instances of Down Syndrome and gastroschisis in Montana over the last several years. The gastroschisis investigation continues with the help of student efforts from the Rollins School of Public Health at Emory University.

Montana's "heelstick" newborn screening follow up has been housed in the FCHB since 1995 and is a part of the MCHDM section. Follow up efforts continue to be a partnership between medical providers and hospitals, the public health laboratory, parents, the FCHB and the CSHCN program. Montana presently screens for four department-required blood tests for PKU, galactosemia, congenital hypothyroidism, and hemoglobinopathies. Interest in adding additional tests has been expressed by the medical community, but in light of fiscal constraints and resistance to increases in existing lab charges, no additional lab screenings have been mandated in the last few years. Montana is monitoring national efforts to recommend additional screening tests in the future. At present, our state lab, which conducts newborn screening for the state, lacks mass spectrometry equipment, which will be necessary for inclusion of some of the additional tests. The lab presently works with out of state labs to facilitate provider requests for additional testing.

Newborn hearing screening is also coordinated by the MCHDM section, in conjunction with the metabolic screening program and the birth defect registry. Montana has increased capacity for newborn hearing screening in the state, moving from approximately 30% of newborns tests 4 years ago to more than 80% at present. The state and the advisory group for this program now face the difficult task of how to facilitate screening in the very small communities where limited resources for testing and follow up exist, and to assure effective follow up, especially in small communities. The group will be examining various approaches to this challenge in FFY 2006.

The MCHDM has been the lead player in development of standardized reporting capacity for local

public health, concentrating on MCHBG and PHHV reporting requirements. The Integrated Data for Evaluation and Assessment (IDEA) Project was designed in 1998 to provide improved support for the delivery of maternal and child health-related services at the state's local public health departments and to improve local and state capability for evaluation of program effectiveness. The Public Health Data System (PHDS) was developed for use at local health departments to support their client case management and reporting capability. PHDS has been designed to support four of the public health programs provided at the local level -- client case management and tracking, an initiative to serve women with high risk pregnancies, family planning and immunizations. The immunization component will include: population of the immunization registry with birth record data; immunization data from the Indian Health Service and participating tribal health departments; and linkage with private providers of immunizations. Interface of the PHDS with the Indian Health Service data system in use in Montana's tribal health department stalled when the IHS decided to establish its own national immunization registry interface protocol for use by all states. The PHDS has been rolled out to 83% of the local public health departments, and plans to convert the web based structure with increased ease of data entry is presently in process.

In 1985, the Montana legislature authorized the creation of a voluntary statewide genetics program, funded by a tax on individual insurance policies. The program provides for newborn heelstick screening follow up, and genetic services and education for the people of Montana. FCHB provides the newborn screening program follow up, referring children identified with metabolic disorders to the CSHCN and genetics programs for intervention and evaluation. In 2004, a formal request for proposal (RFP) process was undertaken to award a new contract for clinical genetic services for Montana after more than a decade of annual renewal of the existing contract. A new contract has been awarded to the previous contractor and services and reporting requirements have become more clearly focused. The 2005 Legislature considered and passed a bill increasing the tax on individual insurances, which provides the funding to support the program. This increase sunsets in 2007, requiring the department to investigate alternative mechanism to fund the programs, with a goal of increasing the base upon which the funding depends.

The Child, Adolescent and Community Health Section houses many of the staff and programs most directly impacting the MCH population. Staff in the section manage and monitor the public health home visiting program for pregnant women and infants, the fetal infant child mortality review, the SIDS prevention, fetal alcohol prevention and youth suicide prevention programs, the early childhood comprehensive systems project, the oral health program, and provides consultation on general child, school and adolescent health issues.

The public health home visiting (PHHV) program has a long history in the state. In 1989, the Montana Legislature enacted legislation establishing the Montana Initiative for the Abatement of Mortality in Infants (MIAMI) and supporting it with general funds. The goals of the legislation compliment the charges in Title V of the Social Security Act, which are to 1) assure that mothers and children, particularly those with low income or with limited availability of health services, have access to quality maternal and child health services, 2) reduce the incidence of infant mortality and the number of low birth weight babies and 3) to prevent of the incidence of children born with chronic illnesses, birth defects or severe disabilities as a result of inadequate prenatal care. The program has continued to evolve, with efforts in 2004 targeting focusing the program on pregnant women and infants, and emphasizing home visiting as the preferred mechanism of providing services. At present, there are 19 contractors for PHHV services, including three tribal programs.

Montana's oral health program is also located in the CACH Section. The oral health program focuses on population based and infrastructure services to develop community awareness of the importance of oral health and to build capacity at the state and community levels. The program has benefited from the State Oral Health Collaborative Systems grant program, which has facilitated focus on system development. The oral health program coordinator has worked with the Primary Care Office and Primary Care Association over the last several years to focus

education and cooperation regarding the importance of oral health and the serious access issues that exist in our state. The oral health program also coordinates school-based efforts to enable schools to conduct dental screening and fluoride rinse programs, and works in conjunction with the WIC, Head Start, Healthy Child Care Montana and the Child, Adult Care Food Program to develop appropriate services for the pre-school population. Training materials for public health and dental professionals were supplied to dental screeners and data recorders on a case-by-case basis to assure standardization and utilization of the Basic Screening Survey (BSS) surveillance instrument developed by the Association of State and Territorial Dental Directors (ASTDD).

The CACH section also supports efforts to prevent Fetal Alcohol Syndrome and Effect through prenatal prevention efforts. This effort was first supported by Congressional set-aside funding focusing on South Dakota, North Dakota, Minnesota and Montana. The project funded $3 million dollars per year to develop a three component effort which included 1) the creation of a Four State FAS Consortium, charged with program development, implementation and evaluation, 2) assessment which included gathering of consistent data with which to accurately assess the incidence and impact of FAS in the region and 3) intervention projects, focused on the prevention of fetal alcohol syndrome and fetal alcohol effect. Montana's intervention was built upon the PHHV/ MIAMI project, adding intensive home visiting and case management for pregnant women at risk of having a child with FAS/FAE. The project also enabled collaborative efforts to support FAS evaluation clinics in the state. Funding for the four-state consortium was no longer earmarked in 2004, and the staff applied for and received a Fetal Alcohol Syndrome Centers for Excellence award from SAMHSA in 2004.

The Fetal Infant and Child Mortality Review (FICMR) program directs and guides local efforts to review deaths of fetuses, infants and children 18 years of age or younger. The purpose of the review is to enable communities to identify risks or challenges in their communities and to implement appropriate prevention measures. State level functions are to compile and examine data looking for patterns and clues indicating statewide and/or legislative policy changes required. Examples of the uses of FICMR data include testimony to the 2005 Montana legislature regarding the importance and need for a graduated driver's license for young drivers, primary seat belt laws for children, and standardized medication administration policy in day care settings. The data was lauded by MCH advocates as useful and supportive of preventive efforts for the MCH population.

SIDS prevention is an ongoing effort in Montana, as in other states. A recent innovation has been the availability of a "Safe Sleep" program, providing safe cribs to needy families across the state. Public Health Nurses in counties and tribal settings may request cribs on behalf of clients who require a safe sleep environment for an infant. Requests for cribs are processed through public health nurses, and the cribs are then ordered and delivered to the public health nurse for delivery to the client. The added benefit of PHN contact and education regarding a safe sleep environment and other preventive information has been a major selling point for the program. Support for the program has been received by the Montana Healthy Mothers, Healthy Babies Coalition, private foundations and the Emergency Medical Services for Children Program.

CACH also provides technical assistance and consultation to local public health and school staff on matters impacting child, adolescent and school health. Efforts to continue general support and development of preventive and supportive Adolescent Health Efforts to develop strong adolescent health services continue with emphasis on the two top causes of morbidity and mortality in Montana: unintentional injury and suicide.

Suicide has, and continues to be recognized in Montana as a major public health concern. The department worked in conjunction with mental health provider, advocates, local partners and others to develop the first Suicide Prevention Plan, which was finalized in 2001. Funding was also obtained from the Governor's office in 2004, and from Preventive Health Block Grant carryover in 2005 to conduct an assessment of resources for suicide prevention in the state, and to support local efforts to prevent youth suicide. A report of the status of effort is attached to this

document. DPHHS partnered with others to submit an application for a SAMHSA Cooperative Agreement to address youth suicide in June of 2005.

The Family Planning program receives a small amount ($25,000) of MCHBG funding which it includes in the contracts with 15 local agencies to provide family planning services in 38 locations. Family planning programs are designated STD programs and all programs have enrolled medical service providers that provide comprehensive breast and cervical screening services to an identified target population. The family planning program serves approximately 28,000 men and women annually, including adolescents. The program helps to decrease the incidence of unintended pregnancies and births to teen mothers, which are MCHBG performance measures.

Statutory Authority for Maternal and Child Health Services Authority for maternal and child health activities within the Department are found in the Montana Codes Annotated (MCA 50-1-2020. General powers and duties of the state include administration of federal health programs delegated to the states; rule development for programs protecting the health of mothers and children (including programs for nutrition, family planning services, improved pregnancy outcomes, and Title X and Title V); accept and expend federal funds available for public health services, and use local health department personnel to assist in the administration of laws relating to public health.

Rules implementing the above authority are found in Title 16, Chapter 24, and sections 901 through 1001 of the Administrative Rules of Montana (ARM). These rules define the State Plan for Maternal and Child Health, including crippled children, family planning and school health. A 1996 addition to the Rules describes the Standards for Receipt of Funds for Maternal and Child Health Block Grant. Newborn screening is required through ARM 16.24.201 through 215. MCH 50-19-301 through 323 authorized and describes the MIAMI project. Administrative rules describing and authorizing case management for high-risk pregnant women are contained in ARM 46.12.1901 through 1925.

/2007/ The Family and Community Health Bureau continues to be the agency within the Montana Department of Public Health and Human Services primarily responsible for services for the maternal child health population. The Bureau has reorganized over the last year. Children's Special Health Services, which is Montana's program for children with special health care needs, has rejoined the bureau and public health division. Major changes in program organization and responsibilities are highlighted here:

Child, Adolescent and Community Health (CACH): This section continues to be responsible for programs and services targeting the childbearing and childrearing populations, offering supportive programs in partnership with local agencies. CACH supports and promotes the Public Health Home Visiting (PHHV) program, which is part of the Montana's Initiative for the Abatem,ent of Mortality in Infants legislation, which was passed in 1989. The initiative included community based efforts to work with high risk pregnant women and infants. The programs provides funding and training to 19 communities, including three tribal programs. The section also supports targeted efforts to identify and support families at risk for Fetal Alcohol Spectrum Disorder, by enhancing the PHHV with the addition of staff able to provide intensive home visiting services for these families. CACH was awarded a Garrett Lee Smith Memorial Grant in 2005, continuing and greatly expanding efforts to develop youth suicide prevention programs in communities across the state. The section is responsible for the Fetal Infant Child Mortality Review and for SIDS prevention efforts in the state. Staff includes the school health and adolescent health consultants.

Children's Special Health Services (CSHS): This section is responsible for system development and service support for children with special health care needs and their families. This section rejoined the bureau on January 1, 2006, and is responsible for

regional speciality clinic development, family support enhancement (in conjunction with the state's Family Voices), and limited direct pay for services. The program works closely with clinic sites and with other programs serving CSHCN and their families, including Part C and the Montana School for the Deaf and Blind. The Newborn Hearing and Metabolic Screening Program and the Birth Defects Registry was moved to the CSHS section in spring of 2006, in order to promote and coordinate clinical follow up and tracking.

Maternal and Child Health Data Monitoring: This section is responsible for development and monitoring of the Maternal and Child Health Block Grant. The section has contracts with 54 of Montana's 56 counties, distributing approximately 42% of the MCHBG award locally to support MCH services identified by and monitored through ongoing community needs assessments. The section also supports abstinence education programs with Abstinence Education funding, and is responsible for the Oral Health Program, which was moved from the CACH section.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC): The WIC/Nutrition Section administers the WIC program in Montana, which offers services through 29 contracts statewide and on in all reservation communities. The section also supports a Farmer's Market Program for WIC clients in select communities.

Women's and Men's Health: This section is primarily responsible for reproductive health services through Title X supported clinics across the state. The section monitors and supports community based efforts to prevent teen and other unintended pregnancies.

The Bureau staff and Advisory Council has developed a strategic plan based upon the information obtained through the MCH Needs Assessment in 2005. Priority needs were established and section activities developed in response to those needs.

An executive order (included as an attachment) to make the FCHB Advisory Council members governor-appointed was proposed. The FCHB Advisory Council members are currently appointed by the FCHB Bureau Chief. The executive order is under review and has not yet been signed. //2007//

C. Organizational Structure

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for the programs and services, which safeguard the health and welfare of Montanans. The department mission is "improving and protecting the health well-being and self reliance of all Montanans." The Director, Robert Wynia, MD oversees the agency, its 3,000 employees and approximately 2,500 contracts and 350 major programs. DPHHS has a biennial budget of about $2 billion.

The Department of Public Health and Human Services (DPHHS) is a " mega agency" encompassing health and human services for the state of Montana. Statewide reorganization of health and human services agencies in 1995 created DPHHS by combining the Department of Social and Rehabilitation Services, the Department of Family Services, and parts of the Department of Health and Environmental Services and the Department of Corrections. During the reorganization, the environmental component of public health was separated and those functions now are carried out by the Department of Environmental Quality.

The reorganization combined public health and Medicaid services into a single division, knowns as the Health Policy and Services Division. In 2003, that division was split to create the Health Resources Division and Public Health and Savety Division.

The DPHHS Director's Office includes staff and programs that support the attainment of the department goals and the divisions' efforts to implement programs. The department has one

deputy director, John Chappius, who also functions as the state Medicaid director. Programs within the director's office are; the Prevention Resource Center; the Office of Planning, Coordination, and Analysis; the Office of Legal Affairs; the Human Resources Office; and the Public Information Office. The Department's four broad goals are:

All Montana children are healthy, safe and in permanent loving homes.
All Montanans have the tools and support to be as self-sufficient as possible.
All Montanans are injury free, healthy and have access to quality health care.
All Montanans can contribute to the above through community service.

DPHHS is organized into eleven divisions. They are:
Addictive and Mental Disorders Division;
Child and Family Services Division;
Child Support Enforcement Division;
Disability Services Division;
Fiscal Services Division ;
Health Resources Division;
Human & Community Services Division;
Operations and Technology Division;
Public Health and Safety Division;
Quality Assurance Division, and
Senior and Long Term Care Division.

The majority of state level activities and services to the maternal and child population take place within the Public Health and Safety Division (PHSD). The mission of PHSD is to "Improve and protect the health and safety of Montanans." Jane Smilie has been the administrator of the Division since January 2005. The Public Health & Safety Division (PHSD) oversees the coordination of the public health system in Montana. The State's public health system is a complex, multi-faceted enterprise, requiring many independent entities to unite around the goal(s) of health improvement and disease prevention at the community-level. These entities include local City/County Health Departments, private medical providers and hospitals, local Emergency Medical Services, Emergency Management agencies and other units of local government. The public health system is a part of the continuum of care available to the citizens of Montana and the PHSD promotes and supports both the availability and the quality of public health services available to Montanans. The Division is organized into six bureaus:

Chronic Disease Prevention & Health Promotion Bureau - Todd Harwell, Bureau Chief
Communicable Disease & Prevention Bureau - Bruce Deitle, Acting Bureau Chief
Family and Community Health Bureau - JoAnn Dotson, Bureau Chief
Financial Operations and Support Services Bureau - Dale McBride, Bureau Chief
Laboratory Services Bureau - Anne Weber , Bureau Chief
Public Health Systems Improvement and Preparedness Bureau - Bob Moon, Bureau Chief

The Health Resources Division admisistrator is Chuck Hunter. The division brings together health resources for children, including CHIP, Children's Special Health Services, and the Children's Mental Health Program. In addition to the children's services, the division houses the primary care and hospital portions of Medicaid. This division is organized into six bureaus:

Acute Services Bureau -- Duane Preshinger, Bureu Chief
Children's Mental Health Bureau -- Pete Surdock, Bureau Chief
Fiscal Services Bureau -- Beckie Beckert-Graham, Bureau Chief
Health Care Resources Bureau -- Jackie Forba, Acting Bureau Chief
Hospital and Clinical Services Bureau -- Brett Williams, Bureau Chief
Managed Care Bureau -- Mary Angela, Bureau Chief

Maternal and Child Health Services as described in the Title V of the Social Security Act are the

responsibilities of the Family and Community Health Bureau (FCHB) and the Health Care Resources Bureau (HRB).

The Family and Community Health Bureau has a staff of 30 and a total budget of approximately $21 million. The FCHB manages approximately 300 contracts with local providers for MCH services including primary and preventive services for women, infants and children, family planning services, tribal programs and WIC. Approximately 91% of the total bureau budget is expended at the local level. The FCHB bureau is organized into four sections, which are:

Child, Adolescent and Community Health (CACH) -- Deborah Henderson, Supervisor
Maternal Child Health Data Monitoring -- position vacant
WIC/Nutrition -- Chris Fogelman, Supervisor
Women's and Men's Health -- Suzanne Nybo, Supervisor

The Health Care Resources Bureau (HCRB) has 18 staff members and an annual budget of approximately $16 million. The bureau is organized in two sections:

Children's Special Health Services (CSHS) -- BJ Archambault, Acting Supervisor
Children's Health Insurance Plan (CHIP) -- Jackie Forba, Supervisor.

An organizational chart of the Montana Department of Public Health and Human Services is available at http://www.dphhs.state.mt.us/aboutus/orgcharts/orgchart.shtml. Organizational charts for the Public Health and Safety Division, the Family and Community Health Bureau, and a combined Human Resources Division and the CHIP/CSHS Bureau are attached as a single document.

/2007/ The Department of Public Health and Human Services had a new director appointed in 2005. Joan Miles, JD, is the former director of the Lewis and Clark County health department. Director Miles also worked as a clinical labortorian in the state and was a Montana state legislator.

The Family and Community Health Bureau has a staff of 32 and a total budget of approximately $21 million, including funding from 13 federal and state sources. The FCHB bureau management includes:

Family and Community Health-- Jo Ann Walsh Dotson, Bureau Chief and MCH Director
Child, Adolescent and Community Health (CACH) -- Deborah Henderson, Supervisor
Children's Special Health Services (CSHS) -- Mary Runkel, Supervisor and CSHCN Director
Maternal Child Health Data Monitoring (MCHDM) -- Ann Hagen-Buss, Supervisor
WIC/Nutrition -- Joan Bowsher, Supervisor
Women's and Men's Health -- Colleen Lindsay, Supervisor //2007//
An attachment is included in this section.

D. Other MCH Capacity

The MCHBG supports 10.69 FTE at the state level. These FTE are all or part of 16 staff members' time. The amount of FTE supported by MCHBG and the role of the staff member are described below:

Section	Staff member	FTE Paid by MCHBG	Role
CACH			
	Dennis Cox	1	Adolescent/School Health
	Deborah Henderson	0.5	CACH Section Supervisor
	Wilda McGraw	1	FICMR, Child Health

Cindy Mitchell	0.5	Admin Support
Cheri Seed	0.5	Oral Health
Sandra Van Campen	0.5	PHHV/FAS Prevention

MCHDM

Sib Clack	0.35	NB Screening & Birth Defects
Kindra Elgen	0.50	MCH Data Manager
Rosina Everitte	0.17	MCH Epidemiology/Statistician
Jack Lowney,	1.00	MCHBG & Contracts
Subtotal of CACH and MCHDM	6.02	

CSHS

Archambault, B.	1.00	Nurse Consultant and Acting Supervisor
Donnelly, M.	0.80	Nurse Consultant and Data System
Gruby, T.	0.87	Accountant
O'Donnell, M.	1.00	Clinic Coordinator
Scott, C.	1.00	Outreach Coordinator
Subtotal	4.67	
Total	10.69	

Jo Ann Dotson's time is cost allocated across the bureau based on staff time, incorporating some MCHBG based on 6.02 FTE. Jackie Forba's time is fully covered by CHIP.

The FCHB Bureau has a staff of 30 and the HRB a staff of 18. All other FCHB state staff and portions of the MCHBG supported staff are paid from other funding, including federal funds (WIC, Title X, Newborn Hearing Screening, SOHCS, SSDI and FAS) and a small portion of general fund. HRB staff outside of the CSHS program is supported by a combination of federal CHIP and state match.

FCHB has one federal staff person, Dianna Frick, who is responsible for coordinating the 2005 needs assessment and the subsequent MCH needs prioritization and strategic planning. Dianna's position will be in existence for two years (Sept. 2004-Sept. 2006) and is a result of FCHB's successful application for a Public Health Prevention Service fellow through the Centers for Disease Control and Prevention.

In addition to program staff, administrative costs are allocated to all programs in the state agency to support fiscal, operations and legal services. Cost allocation is budgeted based on an analysis of services costs anticipated -- for SFY 04, that estimate is for approximately 5.3% of the total budget. In addition, state law allows local health departments to use up to 10% of their funds for administrative purposes. Local agencies have been reported approximately 7.2% of their expenses as administrative costs.

As stated earlier in this application, much of the capacity to address the health needs of the MCH population exists at the local level. MCHBG is distributed to 54 of the 56 counties through MCH Contracts. Those amounts are based on an allocation formula that considers target population and poverty levels. The amount of funding obviously impacts the amount of time and subsequent work,which may be "purchased" with the dollars -- some of the smallest counties receive only $1,000. The funding does require that a designated individual be available to monitor MCH needs. According to the Montana 2004 County Health Profiles, there were approximately 124 public health nurses, 84 registered sanitarians, 14 registered dieticians and 41 health educator FTEs in public health settings across the state. The MCHBG helps support a portion of those positions, and in cases, provides the "anchor" or designated funding for public health in the county.

The Public Health Data System (PHDS) is a system developed for local health departments to use for case management and project reporting. SSDI funding helped in the initial development

phases. The system is supported with approximately $25,000 annually -- to date that amount has been matched or exceeded by various other sources, including Preventive Health Block Grant, Immunizations and Title X. While still a work in progress, the concept of common reporting software is crucial to accurate assessment and documentation of public health services. Administration of the PHDS has been transferred to the Public Health Informatics Section in the Division.The Health Resources Bureau maintains a Family Health Line Since January 2001, the Department of Public Health and Human Services' Family Health Line (1-877-KidsNow) has been the toll-free line with which Montanans can access information about health care programs for children and other health issues sponsored and promoted by the Department. Most of the calls received on the Family Health Line are related to CHIP (the Children's Health Insurance Plan), but approximately one-fourth of the nearly 12,390 phone calls received in 2004 has a referral component, in which the caller is referred to programs, both public and private, including those administered under Montana's Maternal and Child Health Block Grant. The National March of Dimes Toll Free line now provides consumer and provider call in services, with back up teratogenic counseling and assessment available. Montana continues to support the concept of a nationally supported toll free line, similar to the Poison Control Line system created approximately 25 years ago.

March of Dimes and is the Region VIII Councilor forthe Association of Maternal Child Health Programs.

/2007/ The FCHB experienced extensive staff changes during 2005-2006, due in part to retirements and family members moving out of state. Four of the bureau's five sections have new managers, including the CSHS, which was vacant for approximately 2 years. The MCHBG supports 12.25 FTE at the state level.

Employee name Section Role
Dennis Cox CACH Adolescent/Youth Suicide Prevention (vacant as of 7/31/06), currently recruiting
Deborah Henderson CACH Section Supervisor
Julie Chafee CACH FICMR, Child Health, School Health - hired in 2006
Candy Burch CACH Admin Support - hired in 2006
Rae Brown CACH PHHV, FASD Prevention - hired in 2006
Ann Hagen-Buss MCHDM Section Supervisor - hired in 2006
Camie Zufelt MCHDM Data Manager - hired in 2006
Shannon Koenig MCHDM Admin Support - hired in 2006
Theresa Gruby MCHDM Accountant & Contracts
Margaret Virag MCHDM Oral Health - hired in 2006
Mary Runkel CSHS Section Supervisor - hired in 2006
Mary Lynn Donnelly CSHS Nurse Consultant and Data System
Michelle O'Donnell CSHS Clinic Coordinator
Corliss Scott CSHS Admin Support and Outreach
Sib Clack CSHS NB Screening & Birth Defects
Shari Pettit CSHS Nurse Consultant
Rosina Everitte FCHB MCH Epidemiology/Statistician (vacant as of 7/15/06, Dianna Frick hired and will begin 9/18/06)

An executive order (included as an attachment) to make the FCHB Advisory Council members governor-appointed was proposed. The FCHB Advisory Council members are currently appointed by the FCHB Bureau Chief. The executive order is under review and has not yet been signed. //2007//
An attachment is included in this section.

E. State Agency Coordination

Perhaps the sole benefit of the small size of the public health service community in Montana is that coordination of services becomes a relatively easy process. The fact that a few people wear many hats at both the state and local levels and in the private and not-for-profit communities usually results in more thorough coordination of the available services. Everyone knows everyone and many clients are served in common. People work diligently to meet local client needs as efficiently and effectively as scarce resources allow. Local input is sought at the state level, usually in the form of advisory councils or committees and functional work committees.

There are two Advisory Councils that advise the department on programs and services in the Family and Community Health Bureau and the Children's Special Health Services program. The Family and Community Health Bureau Advisory Council is charged with advising "… the Family and Community Health Bureau (FCHB) and the Department of Public Health and Human Services on matters impacting the Bureau's target populations, including pregnant women, women of childbearing age, infants, children to aged 22." The AC Purpose and Guidelines document and the list of 05-06 members is attached. The Council meetings every two months via TC, and advises the department in the interim via e-mail and by phone.

The Family and Community Health Bureau Advisory Council is instrumental in helping link and guide the Bureau. In Calendar 06, the Bureau will undergo a strategic planning update, facilitated by the PHPS and informed by the needs assessment submitted in this application. The strategic planning process will include AC members, contractor representatives, program managers and staff. The FCHBAC members provided effective advocacy for MCH programs during the 2003 and 2005 State Legislature and played key roles in preserving the state's general fund support of the public health home visiting program for high-risk pregnant women and infants addressed in legislation as Montana's Initiative for the Abatement of Mortality in Infants or MIAMI.

The Children's Special Health Services (CSHS) section is located in the Health Care Resources Bureau and coordinates services and activities directly with providers through the Montana Chapter of American Academy of Pediatrics, an advisory committee, public payers such as SCHIP, state employee benefits plan and Medicaid, the Family Voices chapter housed at Parents Lets Unite for Kids (PLUK), the Insurance Commissioners Office and others. CSHS continues to expand their ability to coordinate services with other partners who work with CSHCN. In Montana much of this activity occurs at the local level through service providers. CSHS also works towards coordination at the state level. The State CHIP program is also contained in the HCRB and collaboration with Medicaid is an integral part of operations. The CSHS section receives input and guidance from an advisory group consisting primarily of medical providers, but also including parent participants and advisors. Jo Ann Dotson, the Bureau chief of the Family and Community Health Bureau participates as a staff member on the CSHS Advisory Group.

The PHSD and FCHB also have other Advisory Councils. At present, the PHSD has approximately 35 councils, many of them linked to specific grants. The FCHB has The Birth Outcome Monitoring AC, The Dental Access Coalition, the Family Planning Medical Standards Committee, Fetal Alcohol Syndrome Advisory Council, Fetal Infant & Child Mortality Review Work Group, the Newborn Hearing Screening Task Force, Newborn Screening Advisory Board, the Suicide Prevention Work Group and the WIC Steering Committee. The Governor's office is examining all ACs, and anticipating combining some of these functions into the FCHB AC structure, which will be done over the next year.

FCHB and HRCB Staff participates on several intra and interagency groups targeting the MCH population. Examples of those groups include:

Connecting for Kids -- Primarily designed as an intra agency group, this group began meeting in 2004, in order to address challenges of linking existing programs and services. Programs, including DD, foster care, and others, were facing instances in which children's insurance or other services stopped with no transition plan. This group's stated purpose is to "… look at the systems that serve children in Montana, to enhance coordination of programs, and improve

communications between programs to deliver services in the most efficient manner possible".

Healthy Kids - Quarterly meetings are held with the Office of Public Instruction (which is the state's Department of Education) in order to discuss issues that cross departmental boundaries, such as dispensing medications in the schools, management of biohazards in schools and management of asthma. Dennis Cox helps facilitate that group, setting the agenda every other meeting.

Kid's Count Advisory Council -- This projects is directed by the Bureau of Business and Research of the University of Montana. Funded in Part by the Annie E. Casey Foundation, this project helps to inform health policy discussion and decisions. The project publishes and distributes a Montana specific report every year. This advisory council meetings quarterly. The department also supports the printing and distribution of the Kids' Count Book to local communities.

March of Dimes Board of Directors -- This board meets monthly. Jo Ann Dotson represents public health on this board. The Bureau shares common goals to improve pregnancy outcomes and decrease infant mortality, including that attributable to prematurity, with the March of Dimes organization.

/2007/Reorganization resulted in the move of the CSHS section to the Family and Community Health Bureau effective January 1, 2006. The CSHS Advisory Committee now functions as a subcommittee to the Family and Community Health Bureau Advisory Council. An executive order (included as an attachment) to make the FCHB Advisory Council members governor-appointed was proposed. The FCHB Advisory Council members are currently appointed by the FCHB Bureau Chief. The executive order is under review and has not yet been signed. //2007//

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	0.4	14.2	11.1	14.9	60.7
Numerator	2	78	61	82	167
Denominator	54869	54869	54869	54869	27493
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2005

Medicaid data were used to report on this indicator for 2005. Between 10/1/2004 and 9/30/2005, 167 children were hospitalized with an asthma diagnosis. During this same time, there were 27,473 children under age 5 enrolled in Medicaid.

Narrative:

The results for this indicator have varied since 1998, and the number of children hospitalized with asthma was quite low until 2005, with numbers less than 100. The rate prior to 2005 also appears low compared to HSI 01 results from other states and jurisdictions, although data sources vary so the comparability is questionable. Montana's 2005 source of data for this indicator is Medicaid paid claims data, which captures data for only a small subset of the actual population at risk. The data for 2005 were run using different criteria than in previous years, and as a result the percent of children hospitalized increases dramatically for the reporting year. However, children in lower-income (and possibly Medicaid-eligible) households may be more at risk for asthma due to quality of housing, limitations in medical care and exposure to other risk factors, so this rate may be higher than that of the general population. The recently hired Data

Coordinator for the Family and Community Health Bureau will complete training in Query Path, the Medicaid data system, and this improved capacity for analyzing the data within the Bureau should help to standardize the data reporting in future years.

Montana's Department of Public Health and Human Services (DPHHS) does not currently have access to hospital discharge data. However, negotiations are underway for DPHHS to receive discharge data in the future, which will provide a much more realistic perspective on the total number of hospitalizations related to asthma throughout the state and population groups.

Montana's Title V program does not have an asthma component, but the program does collaborate with projects related to asthma and healthy environments. Montana's Environmental Public Health Tracking (EPHT) Project is working with communities to identify the primary environmental health risks, some of which are possible risk factors for asthma. EPHT activities include a pilot project on asthma, which is expected to generate more representative data through case ascertainment.

A new project called Healthy Air Daycare was initiated in 2005, with collaboration from the Title V program's Child Health Consultant. This program developed a checklist of environmental factors to be reviewed at each daycare site during licensing visits. If the daycare meets a certain criteria, it is awarded a "Healthy Air" sticker that can be placed in the window of the daycare. The program also results in the education of daycare providers about healthy indoor environments for the children they care for.

Environmental health was identified as a priority area during the Family and Community Health Bureau's (FCHB) current strategic planning activities. FCHB is Montana's Title V program. Goals and objectives have yet to be developed for this priority area, but FCHB expects to explore partnerships related to environmental health, and possible ways to include environmental health education into existing programs. Some of the risk factors linked to asthma would be included in these efforts.

The 2005 Behavioral Risk Factor Surveillance Survey (BRFSS) included questions on adult asthma. A call-back survey on asthma among adults and children is currently underway. Results will be available in 2007. This survey will provide more complete information on asthma among Montana's children.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	98.0	84.3	87.0	84.3	88.3
Numerator	4604	4077	4298	4359	4635
Denominator	4698	4836	4943	5172	5249
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FY 2005.

Notes - 2004
This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FY 2004, updated in 2006 with final data.

Notes - 2003

Checking on availability of these data for 2000

Narrative:
Montana's Medicaid program is in a different division than the state's Title V program. Collaboration does occur where appropriate around MCH-specific activities. For instance, the Children's Special Health Services (CSHS) section collaborated with Medicaid's Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program to promote the awareness of the medical home concept for CSHCN. Hearing and mandated genetic screening also occur for the majority of Montana's children, regardless of whether they are Medicaid enrollees or not. Efforts to increase the percent of infants screened are ongoing through the development of new partnerships, support of current relationships and exploration of new legislation or guidelines to support screenings.

The percentage of Medicaid-enrolled infants screened has ranged from 84% - 98% over the past five years. Due to the small size of Montana's population, 10 years of data might provide a more realistic indication of trend for this indicator. Changes in Medicaid policies, eligible population, access to providers, and other factors that could affect access to screenings and cause the data fluctuations are not reflected by the numbers. The variations in the five years reflected here indicate that Montana's percent of infants screened is staying about 80%.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	NaN	100.0	100.0	100.0	100.0
Numerator	0	1	1	1	1
Denominator	0	1	1	1	1
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
A report of the CHIP data base children by age and by procedure codes is not available and is not feasible to program a new report in time to submit with the annual submission of MCHBG. In addition the number of children under one year is not available on the state level vital statistics. Data entered is not correct.

Notes - 2004
A report of the CHIP data base children by age and by procedure codes is not available and is not feasible to program a new report in time to submit with the annual submission of MCHBG. In addition the number of children under one year is not available on the state level vital statistics. Data entered is not correct.

Notes - 2003
These data are NOT available in Montana

Narrative:
Montana's CHIP program does not collect data that can be used for this Health System Capacity Indicator. The data presented in HSCI02 are considered most indicative of this statistic even though children eligible for Medicaid in Montana are not eligible for CHIP.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	72.7	78.4	79.6	81.1	80.6
Numerator	7867	8529	9060	9337	9200
Denominator	10814	10873	11384	11514	11414
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
Montana's Observed to Expected percentage was calculated for the year 2005 with updated stats from Vital Statistics. The numerator is the number of women having 80% or better percentage for this measure. The denomiator is birth cohort for the year in question.

Notes - 2004
Montana's Observed to Expected percentage was recalculated in 2006 for the year 2004 with updated stats from Vital Statistics. The numerator is the number of women having 80% or better percentage for this measure. The denomiator is birth cohort for the year in question.

Notes - 2003
Montana's Observed to Expected percentage was recalculated in 2006 for the year 2003 with updated stats from Vital Statistics. The numerator is the number of women having 80% or better percentage for this measure. The denomiator is birth cohort for the year in question.

Narrative:
The data source for this indicator is vital records. Vital records data for 2005 are still provisional, so this number may shift slightly with finalized numbers. The denominator is the number of births for the given year and the numerator is the number of women ages 15-44 with a live birth during the given year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck index. This number is calculated by Montana's Office of Vital Statistics from reported prenatal visits on the birth certificate.

In 2005, the percent of women with adequate prenatal visits according to the Kotelchuck Index decreased slightly. However, over the past 5 years, Montana has seen a trend towards an increase in prenatal visits. An analysis of data over the past 10 years may be a more useful indication of the trend in adequate prenatal care.

The American Hospital Association Data reports a decline in the number of hospitals throughout the state providing obstetrical care (34 in 2004, 32 in 2005). This number does not include Indian Health Services (IHS) facilities, and so is not a complete representation of delivery sites. However, it may indicate some limitations on where pregnant women can access prenatal and obstetric services.

Several programs coordinated through Montana's Family and Community Health Bureau (FCHB), the State's Title V program, contribute to education on and support for prenatal care. The Public Health Home Visiting (PHHV) program provides home visits to at-risk pregnant women. WIC offers nutrition education and resources. The Fetal, Infant and Child Mortality Review (FICMR) offers information on preventing premature births. As these programs have expanded and become more visible and known in communities over the past several years, the messages on prenatal care are reaching more and more women. Where possible, programs such at WIC are also connecting women with sources of prenatal care, such as Medicaid or private providers.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	98.1	86.6	86.7	88.7	88.7
Numerator	52585	55526	46369	57700	58602
Denominator	53594	64089	53457	65079	66078
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FY 2005.

Notes - 2004
The trend analysis for 2000-2004 revealed continued decreases in the percent of children receiving services, and the true percentage for 2010 at approximately 75%. MCH has limited control over this program and subsequent performance measurement, including the actual yearly indicators and future projections.

Narrative:
These data come from the Montana Medicaid Program's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) report. The percent of eligible children who have received a Medicaid-paid service has remained fairly steady over the past several years. Historical data are not available on why the rate in 2001 was relatively high compared to subsequent years.

Montana's Maternal and Child Health program has limited influence over Medicaid-provided programs. Several MCH programs collaborate with Medicaid to try to increase care or educate Medicaid providers and program staff on possible services and interventions. For instance, the WIC and Children's Special Health Service (CSHS) programs both assist their clients to verify whether they are eligible and initiate enrollment in Medicaid where appropriate.

CSHS, the Child, Adolescent and Community Health (CACH) section and the Oral Health Consultant have all developed relationships with Medicaid to collaborate on programs that will help serve children and facilitate their access to Medicaid services.

Montana struggles with access to providers, particularly providers who will accept Medicaid, which certainly affects this indicator. As populations within the state shift towards larger population centers, rural areas are having more difficulty recruiting and keeping providers. Transportation challenges and distances involved in getting to a health provider can deter families from using services. In some of the state's population centers, providers are over-booked and it may be a challenge to find a physician accepting new patients or Medicaid-eligible clients.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	34.4	34.5	34.1	32.9	34.3
Numerator	3693	3703	3849	3931	4182
Denominator	10731	10731	11276	11960	12182
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FY 2005.

Notes - 2004
This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FY 2004, updated in 2006.

Narrative:
The percent of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) --eligible children who have received dental services during the year has remained fairly steady and low over the past five years, never above 35%.

Montana's maternal and child health (MCH) program has limited ability to affect Medicaid programs. However, the Oral Health Consultant (within the MCH program) has collaborated with Medicaid on dental access issues.

Montana struggles with a shortage of dental professionals in the state. The shortage is even more severe in rural areas and when considering dentists who accept Medicaid and child clients. In 2005, 12 of Montana's 56 counties had no dentists and 15 counties had no dental hygenists. For children with behavioral problems or special needs, finding a dentist who will accept them as a client can be even more challenging.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Indicator	2.0	2.1	0.8	1.0	1.1
Numerator	31	33	12	18	22
Denominator	1570	1600	1555	1892	1957
Is the Data Provisional or Final?				Final	Provisional

Notes - 2005
This indicator is essentially unchanged for 2005, although it was predicted to change significantly from 2004 due to CSHS ability to provide resource and referral information to this population. This service was not instituted until May of 2006 and therefore has not yet affected the reporting of this measure. Medicaid coverage for eligible applicants continues to provide for rehabilitative services. CSHS continues to cover some genetic testing for Medicaid clients in out of state labs that are Montana Medicaid providers. During FFY 2005, 22 SSI beneficiaries received comprehensive evaluation through a Title V sponsored Cleft/craniofacial or Metabolic clinic, not paid for by Medicaid.

Notes - 2004
This indicator is essentially unchanged for 2004. It will change significantly in 2005, due to the capacity CSHS has developed to provide resource and referral information to this population. Medicaid coverage for eligible applicants continues to provide for rehabilitative services. In addition, CSHS is providing resource information to SSI applicants who are not deemed eligible for SSI.

Notes - 2003

In reviewing this standard, it was noted that the CSHCN program calculated the annual indicator based on the number of medicaid children recieving rehab services through Title V as the number participating in CSHS rehab clinics. This does not match the informational guidance requesting the degree to which Title V provides something that Medicaid does not cover. Data in 2003 has been changed to reflect the meaning of the standard. The annual indicator reflects the comprehensiveness of the Montana Medicaid program for children with special health care needs. CSHS has provided assistance only for out of state lab services to diagnosis rare genetic conditions.

Narrative:
The indicator for this measure has remained fairly stable for the past three years. The reporting for this indicator was changed in 2003 to be more in keeping with the requested data, resulting in a drop in the indicator from the previous year.

This indicator is essentially unchanged for 2005, although it was predicted to change significantly from 2004 due to Children's Special Health Services' (CSHS) ability to provide resource and referral information to this population. This service was not instituted until May of 2006 and therefore has not yet affected the reporting of this measure. Medicaid coverage for eligible applicants continues to provide for rehabilitative services. CSHS continues to cover some genetic testing for Medicaid clients in out of state labs that are Montana Medicaid providers. During FFY 2005, 22 SSI beneficiaries received comprehensive evaluation through a Title V sponsored Cleft/craniofacial or Metabolic clinic, not paid for by Medicaid.

In 2005-2006 CSHS implemented plans to open a third Regional Pediatric Specialty Clinic in west-central Montana. This third clinic will improve Montana CSHCNs' access to specialty services. Over the past several years, CSHS has moved away from providing direct services, and focused more on facilitating the care of CSHCN through other programs and connecting CSHCN with other resources. As a result, CSHS funds for direct health care and rehabilitative services can be more strategically directed towards filling gaps and covering needs not addressed by Medicaid or other coverage programs and service providers.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2005	other	3	3.6	6.6

Notes - 2007
This measurement is not captured as of yet by Vital Stats. We are hopeful with the implementation of new parameters on the electronic birth certificate that payment source will be available to us in the future. In lieu of this data, the Medicaid percentage of 45.5% was used across the board on every measure to indicate overall low SES burden.

Narrative:
Vital statistics data does not yet capture payment source related to birth records. These data may be available in the future as the electronic birth certificate is further developed. To produce the percentages shown, 45.5% of the total number of low birth weight births were attributed to

Medicaid, and 54.5% to non-Medicaid. The division is based on Medicaid data showing that 45.5% of births in the state are covered by Medicaid. Until Montana has more reliable results on this HSCI, the value of interpretation is limited. For detail on low birth weight-related activities in Montana, please see the narrative for State Performance Measure 8.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2005	other	2.7	3.3	6

Notes - 2007
This measurement is not captured as of yet by Vital Stats. We are hopeful with the implementation of new parameters on the electronic birth certificate that payment source will be available to us in the future. In lieu of this data, the Medicaid percentage of 45.5% was used across the board on every measure to indicate overall low SES burden.

Narrative:
Vital statistics data does not yet capture payment source related to birth records. These data may be available in the future as the electronic birth certificate is further developed. To produce the percentages shown, 45.5% of the total number of infant deaths were attributed to Medicaid, and 54.5% to non-Medicaid. The division is based on Medicaid data showing that 45.5% of births in the state are covered by Medicaid. Until Montana has more reliable results on this HSCI, the value of interpretation is limited.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	other	38	45.5	83.5

Notes - 2007
This measurement is not captured as of yet by Vital Stats. We are hopeful with the implementation of new parameters on the electronic birth certificate that payment source will be available to us in the future. In lieu of this data, the Medicaid percentage of 45.5% was used across the board on every measure to indicate overall low SES burden.

Narrative:

Vital statistics data does not yet capture payment source related to birth records. These data may be available in the future as the electronic birth certificate is further developed. To produce the percentages shown, 45.5% of the total number of infants born to women receiving prenatal care in the first trimester were attributed to Medicaid, and 54.5% to non-Medicaid. The division is based on Medicaid data showing that 45.5% of births in the state are covered by Medicaid. Until Montana has more reliable results on this HSCI, the value of interpretation is limited.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2005	other	36.7	43.9	80.6

Notes - 2007
This measurement is not captured as of yet by Vital Stats. We are hopeful with the implementation of new parameters on the electronic birth certificate that payment source will be available to us in the future. In lieu of this data, the Medicaid percentage of 45.5% was used across the board on every measure to indicate overall low SES burden.

Narrative:
Vital statistics data does not yet capture payment source related to birth records. These data may be available in the future as the electronic birth certificate is further developed. To produce the percentages shown, 45.5% of the total number of women with adequate prenatal care (based on the Kotelchuck Index) were attributed to Medicaid, and 54.5% to non-Medicaid. The division is based on Medicaid data showing that 45.5% of births in the state are covered by Medicaid. Until Montana has more reliable results on this HSCI, the value of interpretation is limited.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2005	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2005	150

Narrative:

These data come from the state CHIP and Medicaid programs. The poverty level-related eligibility for Medicaid in Montana is lower than in other states nationwide (according to TVIS data for 2004) for infants, but similar to other states in the region. For CHIP, a comparison of Montana's poverty level-related eligibility for infants shows that it is lower than the majority of other states nationwide and within the region.

During the last state legislative session, in 2005, an increase in funding was approved for CHIP, allowing CHIP to cover another 3,000 children and immediately enroll all children on the waiting list.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2005	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2005	 150

Narrative:
These data come from the state CHIP and Medicaid programs. The poverty level-related eligibility for Medicaid is similar to other states (according to TVIS data for 2004) for children, but the percent of poverty-level eligibility for CHIP is lower than most states that cover similar age ranges.

During the last state legislative session, in 2005, an increase in funding was approved for CHIP, allowing CHIP to cover another 3,000 children and immediately enroll all children on the waiting list.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2005	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2005	

Notes - 2007
SCHIP does not cover pregnant women over 18 years of age.

Narrative:
These data come from the state CHIP and Medicaid programs. The poverty level-related eligibility for Medicaid is lower than most other states (according to TVIS data for 2004) for pregnant women, but the same as other states in the region. Montana's CHIP program does not cover pregnant women over 18 years of age.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	1	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

Notes - 2007
Active collection of birth defects data was suspended in 2005. Discussions continue regarding possible future methods of collecting and using birth defects data.

Montana received a PRAMS grant for a Point-in-Time survey in 2002. The funding application for an additional PRAMS grant was not successful.

Narrative:
The Family and Community Health Bureau (FCHB), Montana's Title V Program, does not have purview over the majority of the databases and surveys mentioned, with the exception of WIC, PRAMS, newborn screening, and the birth defects surveillance system. Therefore, while the Bureau is often involved in discussions regarding vital statistics data and linkages, it may not be the decision-maker.

Montana's Office of Vital Statistics is currently moving towards linking birth and death records. FCHB does have access to de-identified birth records and the death records (in SAS format), but these files are not linked. FCHB does not currently have access to Medicaid Paid Claims Files, although staff training on the Medicaid data system is planned. However, those files are not linked with birth certificates.

The WIC data system is expected to undergo an upgrade over the next several years. The current system is somewhat unwieldy and is not linked to birth certificates. FCHB does have access to WIC data, but not linked WIC-birth certificate data.

Efforts to link birth certificates and newborn screening data are currently underway. The Newborn Screening Coordinator in Children's Special Health Services is coordinating the effort.

Hospital discharge data are currently unavailable to Montana's Department of Public Health and Human Services (DPHHS). Negotiations are currently underway so that the data will be available to DPHHS in future years.

Montana has birth defects surveillance data through 2005. Active collection of birth defects data was suspended in 2005. Discussions continue regarding possible future methods of collecting and using birth defects data. All of the data collected thus far are maintained by FCHB. Plans for a report on cardiac defects from existing data are in process, with the final report anticipated to be available in the Fall of 2006.

Montana received a PRAMS grant for a Point-in-Time survey in 2002. The funding application for a PRAMS grant in 2006 was not successful. The 2002 data are maintained by FCHB. At this time, FCHB is unable to conduct an independent PRAMS-like survey due to funding and staff limitations. However, possible additional and alternative data sources continue to be explored.

MCH data capacity development was identified as a Bureau priority during strategic planning. Several goals and objectives have been introduced to assist the Bureau in collecting, using and managing data. A Bureau data advisory group will begin meeting in late 2006 and will include representatives from all of the Bureau sections, as well as FCHB's data coordinator and the MCH epidemiologist. The objectives for the group include developing guidelines for data collection and sharing and conducting an assessment of MCH data needs and uses. The advisory group will help to coordinate data requests and consistent responses, as well as improve the Bureau's knowledge of MCH data sources and responsible data use.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2007

Narrative:
Montana's Office of Public Instruction (OPI) conducts and maintains the data from the Youth Risk Behavior Survey. While the raw data are not available to the Title V program, the results of the survey are distributed in published form, and are also easily searchable and obtainable from the OPI website or the national YRBS website. The YRBS has been conducted in Montana every other year since 1993, with the most recent results available for 2005. Montana's Title V program frequently uses YRBS data for grant applications and reports, and it was a valuable source of information for the five-year maternal and child health needs assessment.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Montana's maternal and child health needs assessment process is continuous. Data are collected and analyzed throughout the five-year period. The needs assessment document is an opportunity to compile data and reflect on the complete picture of MCH needs and programs in Montana. Following the submission of the 2005 MCH needs assessment, and using the assessment as a guide, Montana's Family and Community Health Bureau (FCHB) will begin a strategic planning process to further prioritize MCH needs and identify how the FCHB can address them. The strategic planning process will continue the assessment process and ensure the use of previously collected assessment data. In addition, questions were included on the stakeholder survey sent to providers regarding how the process could be useful to them. The needs assessment results will be distributed to stakeholders around the state and available on the state website, which will help to generate interest in the process and encourage use of the needs assessment results. Finally, counties receiving MCH block grant funds are required to conduct their own needs assessments every five years, and those results are incorporated into the state's data collection process.

Beginning in 2002, meetings were held at the state level to determine how the state would develop the needs assessment. The Family and Community Health Bureau within the Montana Department of Health and Human Services submitted applications for two student interns in 2003. The students were responsible for conducting key informant interviews with stakeholders throughout the state and updating data from the 2000 needs assessment during June-August of 2004. FCHB also submitted an application for a Centers for Disease Control and Prevention Public Health Prevention Specialist to be assigned to Montana to assess the needs of the MCH populations. The prevention specialist arrived in Montana at the end of August, 2004.

Two groups at the state-level were primarily responsible for shaping and directing the needs assessment process: the Family and Community Health Bureau Advisory Council (FCHB AC) and the Family and Community Health Bureau Managers. The FCHB AC includes representatives from partner organizations throughout the state, including the March of Dimes, local health officers, WIC, family planning, education, urban and rural local health departments, Indian Health Services, nurses associations, and providers. The Council was involved in determining the approach and the final format of the needs assessment survey, as well as reviewing the final document. The FCHB AC will also be an integral part of the strategic planning process and the ongoing prioritization of maternal and child health needs and activities.

The Family and Community Health Bureau Mangers is comprised of the chief of the Family and Community Health Bureau and the managers of the four sections of the Family and Community Health Bureau: Maternal and Child Health and Data Monitoring; Child, Adolescent and Community Health; Women's and Men's Health; and, Women Infants and Children (WIC)/Nutrition. The managers decided the approach and focus of the community participation component of the needs assessment, participated in the development of the surveys, and reviewed and advised on the content of the final needs assessment document.

B. State Priorities

Selection and prioritization of state needs is an ongoing process requiring assessment of health status and system functioning indicators as well as availability of financial and human resources. Changing expectations of public health impacts the priority selection. The evolution of public health in Montana and the nation continue, moving from what was essentially individually-based services, often providing primary care or a proxy for primary care services towards a system that is population-based, including needs assessment, policy development and assurance. Fiscal and human resource challenges affect every state, but are perhaps more distinct or apparent in

communities where the rural/frontier nature and sparse distribution of clients and providers place multiple demands upon a very fragile public health infrastructure.

The following list of priority needs was generated based on a statewide survey of consumers and those caring for infants, children and families. A copy of the consumer and professional survey is attached to this section. The survey was distributed to WIC and Head Start clients, WIC and Head Start program staff and primary care and public health providers.

This survey provided public input into the development of a list of priority needs, which was further assessed based on the following criteria:

· Existence of data supporting the need
· Evidence that the MCH population, including infants, children, adolescents, children with special health care needs, women of childbearing age and their families were the target audience of the priority.
· Availability of resources and capacity within the public health system (not necessarily the MCH agency) to help address the issue.

This priority list will be the basis of the strategic planning process, which will involve the FCHB Advisory Council, the FCHB staff and local partners and consumers during FFY 06. The needs assessment will inform participants in the strategic planning process. It is anticipated that further prioritization will take place during the strategic planning process, and that the priority list will continue to change and evolve as new data, which will be part of the ongoing needs assessment, is revealed.

This list does not address overarching issues, which impact every one of the priorities. The issues include:

· The importance of a functioning public health system -- the public health system addresses the core functions of public health including assessment, policy development and assurance through the essential services. Included in those services are the responsibility to have appropriate training of public health professionals and partners, epidemiological capacity with which to analyze information regarding the population, and excellent networking among traditional and non-traditional public health providers.
· Recognition of disparity and its impact on the health of the MCH population. -- Examples include disparity in the efforts to promote the health of females in society, as well as disparity between ethnic groups, age groups (i.e. school-aged children) and urban and non-urban dwellers. Recognition of, and efforts to address these disparities is an overriding concern, as they impact all MCH priorities.

Priority Issues

1. Increase access to health care for MCH populations, including children with special health care needs.
2. Increase insurance coverage of MCH populations.
3. Promote and improve oral health services for MCH populations.
4. Reduce the rate of intentional injuries in MCH populations, including, but not limited to the incidence of domestic violence and youth suicide.
5. Promote and support families to raise children in safe and nurturing environments.
6. Reduce the rates of preventable illness in children and adolescents, including obesity and vaccine preventable illnesses.
7. Prevent substance use in MCH populations.
8. Promote access to mental health services for MCH populations.
9. Promote efforts to continue to decrease the incidence of unintended pregnancies.

Efforts to update and re-examine priorities are done annually, in the form of pre-contract surveys

to all contract counties. The surveys are distributed in February of each year, and elicit county responses on topics such as the priority needs impacting the MCH target populations. The Family and Community Health Bureau Advisory Council receives and reviews summaries of the annual pre-contract surveys. Staff also has the responsibility to monitor data and available statistics.

/2007/
For the 2007 MCH Block Grant (MCHBG) submission, Montana adjusted the state's priorities to reflect the priority areas in the newly-developed Family and Community Health Bureau (FCHB) strategic plan. FCHB is Montana's Title V program. The revised list of FCHB priorities is below (please note that the priorities are not ranked). Underneath each priority is a list of any related state and national performance measure(s). The new priority areas are based on discussions and strategic planning activities, and are an evolution from last year's priorities, which were in turn based on the 5-year MCH needs assessment. The priorities listed in this year's MCHBG application are expected to stay the same for the next 5 years, although periodic reviews of the strategic plan may result in some revised and updated priority areas. A discussion of the strategic planning process and the development of this year's priorities follows the list of priority areas.

State Priorities
1) Environmental health
Montana expects to develop a state performance measure related to environmental health in the future. A new project called Healthy Air Daycare, which assesses the environmental health of daycares as a part of licensing visits, has recently been implemented and data are expected to be available within the next year.

2) Family support and education
NPM 2, NPM 3, NPM 5, NPM 6, NPM 8, NPM 10, NPM 11, NPM 15, NPM 16
SPM 1 (unintended pregnancy)
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 7 (firearm deaths among youth aged 5-19)

3) Mental health and substance abuse
NPM 8, NPM 15, NPM 16
SPM 2 (abstaining from alcohol use during pregnancy)
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 6 (abstaining from cigarette smoking during pregnancy)

4) Nutrition and obesity prevention
NPM 11, NPM 14

5) Promotion of preventive and accessible health care
NPM 1, NPM 2, NPM 3, NPM 4, NPM 5, NPM 6, NPM 7, NPM 9, NPM 12, NPM 13, NPM 17, NPM 18
SPM 5 (Medicaid-eligible children who receive dental services)

6) Reproductive and sexual health
NPM 8, NPM 15, NPM 17, NPM 18
SPM 1 (unintended pregnancy)
SPM 2 (abstaining from alcohol use during pregnancy)
SPM 6 (abstaining from cigarette smoking during pregnancy)

7) Unintentional injuries
NPM 10
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 7 (firearm deaths among youth aged 5-19)

8) Family and Community Health Bureau capacity development
FCHB capacity development relates to all of the performance measures. Increased staff capacity in data management, organizational relationships and management skills will contribute to their work in all MCH areas.

Strategic Planning Process
Subsequent to the completion of Montana's five-year MCH Needs Assessment in 2005, FCHB began to develop a five-year strategic plan. Two large stakeholder meetings were held in late 2005. The meeting participants included FCHB staff, FCHB Advisory Council Members, Children's Special Health Service (CSHS) Advisory Council members, and other Department of Public Health and Human Services (DPHHS) partners in MCH activities.

The first meeting, in October, established the drafts of the vision, mission, guiding principles and priority areas. The priority areas were based on the results of the statewide MCH needs assessment. Following the meeting, a small workgroup was formed for each of the priority areas, and the workgroup members developed goals and objectives related to each area.

The second large stakeholder meeting, in December, used the CAST-5 tool to identify and discuss FCHB capacity needs. Holly Grason, of Johns Hopkins University, was the facilitator. The following capacity needs were identified as priorities:

Data Capacity:
- Adequate data infrastructure (access to more and better data/strategic use of data)
- More capabilities related to translation and communication of data
- Staff with basic data skills in all units/programs of FCHB, and additional staff with advanced skills in data analysis

Organizational Relationships:
- Improved collaborative working partnerships with state and local health programs
- Expanded relationships with additional stakeholders, policy makers, advocacy groups, funders, and the business sector

Skills:
- Staff with basic data skills in all units/programs of FCHB, and additional staff with advanced skills in data analysis
- Enhanced management and organizational development skills among staff
Three small workgroups, one for each capacity need topic area, were formed to brainstorm current activities and desired activities related to each capacity need. The brainstormed ideas were then turned into goals and objectives. To include the capacity needs in the strategic plan, an eighth priority area was developed.

The most recent version of the strategic plan is attached to this section. Next to each priority area is a description of the scope of activities that fall under that area and the goals and objectives developed thus far. Please note that the strategic plan is still in draft form and not all sections are complete. Many of the objectives are still being revised so that they fit into the SMART format. The plan is currently being reviewed within each of the FCHB sections to ensure that all ongoing, planned and appropriate desired activities have been included and that the plan is still relevant given recent staff turnover and alterations in projects. The FCHB staff position(s) responsible for each objective and for the ongoing evaluation of that objective will also be determined in the section meetings or larger Bureau meetings. FCHB anticipates finalizing the strategic plan in the Fall of 2006, with periodic reviews and updates to occur after that point. //2007//

An attachment is included in this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective		99.9	99.9	100	100
Annual Indicator		100.0	100.0	100.0	100.0
Numerator		6	4	2	2
Denominator		6	4	2	2
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

Notes - 2005
Two confirmed cases of PKU were referred for case management and primary care provider consultation to a contracted pediatric specialist of The Children's Hospital in Denver, Colorado. An additional initial positive PKU came from a postmortem test on a deceased newborn. No potential or confirmed cases of galactosemia occurred in 2005. Staff in the Children's Special Health Services section do direct follow-up with the contracted pediatric specialist for PKU and GALT positive results to ensure that appropriate consultation is provided for the affected baby's primary care physician and dietary management by the family.

Notes - 2004
Two cases of galactosemia were referred for case management by nurse consultants in Children's Special Health Services.

Mandatory tests in MT = PKU, Galactosemia, Congenital Hypothyroidism, hemoglobinopathies.
Optional tests available = Cystic Fibrosis,

· Congenital Adrenal Hyperplasia , Biotinidase Deficiency* ,· Acylcarnitine Profile*
Fatty Acid Oxidation Disorders

§ Medium Chain Acyl-CoA Dehydrogenase Deficiency
§ 3-Hydroxyacyl CoA Dehydrogenase Deficiency
§ Very Long Chain Acyl-CoA Dehydrogenase Deficiency
§ Short Chain Acyl-CoA Dehydrogenase Deficiency
§ Carnitine Palmitoyltransferase Deficiency
§ Glutaric Acidemia Type II
§ 2,4 Dienoyl-CoA Reductase Deficiency
§ Trifunctional Protein
§ Isobutyryl-CoA Dehydrogenase Deficiency
§ Short Chain Hydroxy Acyl-CoA Dehydrogenase Deficiency
§ Carnitine Translocase Deficiency
§ Carnitine Uptake Deficiency

o Organic Acidemia Disorders

§ Glutaryl CoA Dehydrogenase Deficiency Type I
§ Propionyl CoA Carboxylase Deficiency
§ Methylmalonic Acidemia (mutase, Cbl A and Cbl B, Cbl C and Cbl D)
§ Isovaleryl CoA Dehydrogenase
§ 3-Methylcrontonyl CoA Carboxylase Deficiency
§ Mitochondrial Acetoacetyl CoA Thiolase Deficiency
§ 3-Hydroxy-3-Methylglutaryl-CoA Lyase Deficiency
§ Malonic Acidemia
§ 3-Methylglutaconyl CoA Hydratase Deficiency

§ Medium Chain Hydroxy Acyl-CoA Dehydrogenase Deficiency
§ Medium Chain 3-Ketoacyl-CoA Thiolase Deficiency
§ 2-Methylbutyryl CoA Dehydrogenase Deficiency
§ Multiple Carboxylase Deficiency
§ 2-Methyl-3-Hydroxybutyryl CoA Dehydrogenase
· Aminoacidopathies* (tested by Tandem Mass Spectrometry - MS/MS) (CPT code: 82136, cost $4.25)
o Maple Syrup Urine Disease
o Homocystinuria
o Citrullinemia
o Arginninosuccinic Acidemia
Tyrosinemia (type I, II, III)

Notes - 2003
Prior year data used incorrect denominator and numerator -- was reporting total births and total screened, which is NOT what was required here.

a. Last Year's Accomplishments
In 2005, Montana's required panel of four tests (PKU, galactosemia, congenital hypothyroidism and hemoglobinopathies) were performed on an estimated 97% of the birth cohort. This provisional estimation was based on extrapolated data from manual comparison of Montana birth certificates for babies born in 2005 with newborn screening results in the software used by the Montana Public Health Laboratory in the department. (Previous year's calculations were based solely on screening data without comparison to birth certificate data to ensure that only 2005 births were included and that only babies born in Montana were included and not babies born in surrounding states and who were transferred to NICU hospitals in Montana.) All future data will be based on comparison of birth certificate data to screening data and 2005 data will be finalized in the 2008 application. (Refer to FORM 6 for details of screening results for the mandatory tests)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Link newborn heelstick screening data with Montana birth certificates				X
2. Identify babies with Montana birth certificates who have no newborn screening data within two months of their birth and determine reason for no screening			X	
3. Continue to ensure that all newborns with confirmed PKU or galactosemia conditions are referred to the contracted pediatric specialist for follow-up and primary care physician consultation		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In 2006, Montana's required panel of newborn bloodspot screening tests remains unchanged. Optional tests are available -- either through the Montana Public Health Laboratory or through out-of-state laboratories. (Montana does not at this time have in-state MS/MS capability.) The optional tests currently available encompass all the 25 tests in addition to Montana's mandatory panel of 4 tests that are recommended by the American College of Medical Genetics as being the

national mandatory standard. In the first three months of 2006, a task force of 10 members and 7 departmental staff met to "examine NBS and genetic services and resources in Montana and recommend how best to provide the people of the state with coordinated genetics and NBS services by efficiently and effectively using available and anticipated revenues" and "to identify the criteria that must be met in the State's plan to respond to the national charge to expand newborn screening and related services." The task force included two state legislators, a retired physician who is also a former legislator and former contracted advisor to the Children's Special Health Services section, a physician representing Montana's American Association of Pediatricians, a clinical geneticist, a representative of the Montana March of Dimes, a physician representing neonatologists, and the MCH Director of the Billings Area Indian Health Services. This group defined two goals: (1) that every baby born in Montana receive a mandatory panel of currently AAP-recommended newborn screening tests and (2) that every person in Montana with positive newborn screening results receive an appropriate continuum of follow-up care. They made 14 specific recommendations for services to be included in that continuum of care. (See attached)

The state's newborn screening brochures for both bloodspot and hearing screening have been updated to include parent education toolkit material developed by the Louisiana State University Health Sciences Center under contract with HRSA. Because Montana's major minority group is Native American, photographs of Montana Native American parents and their children were included in all the generic brochures for both bloodspot and hearing screening and highlighted in the brochures that will be distributed in areas of the state serving highest concentrations of Native American families.

c. Plan for the Coming Year

The major activities planned for 2007 are to : (1) automate the current manual of newborn bloodspot screening data with Montana's birth certificates to identify those babies born in Montana who do not have the mandatory panel of screening tests: (2) continue to perform follow up with hospitals and/or primary care physicians on retesting or diagnostic testing for all positive results for the mandatory panel of newborn screening, as well as for optional tests: and (3) distribute educational brochures concerning newborn bloodspot screening to all birthing facilities, OB/GYN practices and public health departments across the state (4) submit legislative request to expand NBS panel to the recommended panel supported by the AAP.

Documentation of the nature of the Montana births without mandatory screening (such as unassisted home births, parental refusal at birthing hospitals) will identify educational outreach opportunities for the program. Consistent monitoring of screening and diagnostic testing results will provide assistance to the ongoing management of the patients of the primary care physicians and provide accurate surveillance data for the state.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	0	0	54.2	54.5	55
Annual Indicator	NaN	54.0	54.0	54.0	54.0
Numerator	0	188	188	188	188
Denominator	0	348	348	348	348
Is the Data Provisional or Final?				Final	Final

	2006	2007	2008	2009	2010
Annual Performance Objective	55.3	55.6	55.6	55.6	55.6

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

A sample of parents representing multiple regional pediatric specialty clinics were surveyed at the Regional Pediatric Specialty Clinics in Billings and Missoula. The surveys are not identical but represent parent satisfaction. All respondents reported a satisfaction rating of over 91%. Gaol for 2006 is 93% with a standard survey tool developed by clinic site, CSHS, and parents.

Notes - 2004
Reporting on this performance measure is unchanged. Ongoing client satisfaction surveys are conducted at Pediatric Specialty Clinics. The Billings regional clinic site reports a 98.19% satisfaction rating on being involved in decisions and being listened to during clinic visits. This sample is small and therefore not representative of the cshcn population in general. This number will be modified in 2005 to represent a larger sampling of cshcn clients.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
Children's Special Health Services (CSHS) has worked diligently to find creative solutions to improve performance in this area. CSHS continued its partnership with Parents Let's Unite for Kids (PLUK), MT's family advocacy program for children with special needs, through their joint efforts on the application for an incentive award from the Champions for Progress Center at the Early Intervention Research Institute. Parents were included in writing the incentive award proposal as well as attending the Champion's For Progress meeting as a Montana team member.

Parents continue to actively participate on the CSHS advisory committee that assisted in the planning of the CSHS annual conference. The CSHS annual conference included the topic of autism that incorporated parents as trainers and consultants. During the conference a CSHS activity plan for the upcoming year was outlined with parent participation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued active parent participation in Children's Special Health Services (CSHS) advisory board.				X
2. Annual CSHCN diagnosis specific conference with family participation/presentation.				X
3. Ongoing parent satisfaction survey's--Regional Pediatric Specialty Clinics.				X
4. Parent partication in Champions for Progress meeting; Development of CSHS Activity Plan.				X
5. Partnership building with Parents Let's Unite for Kids (PLUK), parents and CSHS.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CSHS adopted an action plan to allow parents more discretion as to how they want to spend CSHS financial assistance for medical services. This policy change gives parents more flexibility in prioritizing and managing financial resources for their child's care.

A parent representative participated in the hiring process of the new CSHS supervisor, Mary Runkel, RN, BSN.

A contract with PLUK/Family Voices is being developed to assist with parent participation and communication activities. Specific project contract proposals include: a survey of parents of deaf or hard of hearing infants receiving family to family support; assessing other state Family Voices programs and activities; and participation on the CSHS data stewardship committee. The results will be used to plan for the upcoming years activities and enhance parental input to program activities.

c. Plan for the Coming Year
CSHS is exploring the possibility of parent participation in the Utah Leadership Education in Neurodevelopmental Disabilities Regional Program (ULEND).

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	0		52	52.2	60.2
Annual Indicator	NaN	51.7	51.7	51.7	51.7
Numerator	0	361	361	361	361
Denominator	0	698	698	698	698
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	52.6	52.8	53	53.2	53.4

Notes - 2005
In 2004, number was calculated on 12.8% of population under age 18 x CSHS program data for CSHCN with medical home. For 2005 reporting, CSHS is maintaining the reporting of national survey data for continuity purposes. Program data on Primary Care Providers among the CSHCN population is reported in narrative section.

CSHS continues to emphasize coordination of care between pediatric specialty clinics and primary care providers. With the addition of the 3rd Regional Pediatric Specialty Clinic Site in 2006, this number is expected to grow. Continued education of primary care providers though staff attendance at th Montana Academy of Pediatrics annual meeting and other onsite visits are also expected to support this PM.

Following the MCHBG review, the targets for 2006 - 2010 were reset to more realistically reflect the data source being used.

Notes - 2004
Number is calculated on 12.8% of population under age 18 x CSHS program information for CSHCN with medical home.

With the continued focus on coordination of care within the medical home by programs such as Early Periodic Screening Diagnostic Treatment, this number is expected to continue to increase.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
Children's Special Health Services (CSHS) continued tracking medical home utilization for children who received specialty clinic and other services through the CSHS program. Regional Pediatric Specialty Clinics make referrals for primary care for children who do not have a medical home. Follow-up care for children who attended specialty clinics continued to be coordinated through a child's medical home. CSHS staff participated in the Early Periodic Screening Diagnostic Treatment (EPSDT) Medicaid Project to promote the awareness of the medical home concept.

The children's special heath care needs (CSHCN) portion of the MCH Block Needs Assessment was conducted by a CDC Prevention Specialist in collaboration with pediatrician Dr. Marion Kummer, who received a Community Access to Child Health (CATCH) Grant to conduct focus groups and collect information on CSHCN and their families. The needs assessment survey was completed in late 2005 and early 2006 and preliminary data was presented to public health care providers at the 2006 Spring Public Health Conference. The final data should be available in late 2006.

CSHS program information has been made available to the DPHHS website www.cshs.mt.gov. The website has multiple links of interest to CSHCN parents and providers, including a link to Parents Let's Unite for Kids (PLUK).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All regional pediatric specialty clinic participants are tracked and referred to medical home.	X			
2. Analyze data from 2005 CSHCN needs assessment conducted in conjunction with CATCH Grant medical home project.				X
3. Children's Special Health Services (CSHS) web-site developed, including medical home links.				X
4. CSHS staff participate in Early and Periodic Screening, Diagnosis and Treeatment (EPSDT) Medicaid Project and promote awareness.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CSHS contracts with Laura Nicholson, MD, Developmental Pediatrician, CSHS Medical Advisor, and Chair of the CSHS Advisory Committee to promote the medical home concept in the medical community.

CSHS program information is now available at www.cshs.mt.gov. The site provides families,

providers and others with information about CSHS, pediatric clinics, resources, and links to web-sites, such as PLUK. Family stories and pictures vividly describe the impact of CSHS in the lives of Montana's special needs children.

CSHS staff serve as consultants in Missoula's City/County foster care/medical home project, Follow the Child (FTC). FTC educates foster parents regarding the medical needs of foster care children and provides coordination between foster parents and a child's medical home and with specialty care providers. CSHS facilitated a presentation of FTC to the DPHHS Connecting for Kids Committee as a means of promoting project interest and support.

2005 CSHS data indicates that 68% of 4289 CSHCN receiving services through the CSHS program had a primary care provider. CSHS continues to promote medical home activities through the Regional Pediatric Specialty Clinics with referrals and coordinated follow-up of specialty clinic evaluations.

c. Plan for the Coming Year
Dr. Laura Nicholson, CSHS Medical Advisor and CSHS Advisory Committee Chair has expressed an interest in instituting a medical home project. CSHS plans to explore options for a pilot project to promote medical homes which may include a social worker or nurse coordinator in a pediatric office to facilitate the coordination of care for CSHCN.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	0	0	50	50.3	78.5
Annual Indicator	NaN	48.8	48.8	48.8	48.8
Numerator	0	350	350	350	350
Denominator	0	717	717	717	717
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	50.4	50.5	50.6	50.7	50.8

Notes - 2005
These data are from the National CSHCN Survey results. Verification of specific benefit plan coverage is not addressed. Children's Special Health Services (CSHS) continues to work to improve adequacy of coverage through partnerships with Montana Medicaid, CHIP, and other insurance companies.

MCHBG reviewers noted the 78.5 target was very high. Note subsequent year targets had been made prior to initial MCHBG submission.

Notes - 2004
The data are from the National CSHCN Survey results.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
Children's Special Health Services (CSHS) was able to stabilize the program's financial assistance arm and provide limited financial assistance to 124 clients during FFY 2005. CSHS continued its policy of assisting families to learn about other resources available to them in their communities and around the state. CSHS has continued to educate the Medicaid Professional Review Organization about specialty services available in Montana. CSHS established itself as a Medicaid and CHIP provider for Metabolic and Cleft/craniofacial clinic services.

CSHS continued its activities to support the CHIP program and to make and receive referrals from CHIP. An electronic data link between CHIP and CSHS is under discussion.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued limited financial assistance for medical services.	X			
2. Continued partnership with Medicaid PRO regarding specialty services in Montana.				
3. Ongoing shared referrals with CHIP.		X		
4. Explore electronic link between Children's Special Health Services (CSHS) and CHIP.				X
5. CSHS established provider status with Medicaid and CHIP for multidisciplinary team clinics.		X		
6. Continue to partner with Medicaid and CHIP for approval of payment for orthodontic care for CSHCN with craniofacial conditions.		X		
7. Provide information to CHIP and other insurance regarding coverage needs of CSHCN.				X
8.				
9.				
10.				

b. Current Activities
In June 2005 CSHS began billing other insurance companies and in October 2005, it began processing claims for Medicaid and CHIP for multidisciplinary cleft/craniofacial and metabolic Clinics. This new process has provided funding for CSHS to offset some of the clinic costs for Montana's underinsured and uninsured children. This process has also provided the regional clinic sites with funding for specialty clinic services. CSHS is currently doing a feasibility study in conjunction with the Regional Clinic Sites regarding decentralizing multi-disciplinary team billing from CSHS to the Regional Pediatric Specialty Clinics.

CSHS policies allow families more flexibility in determining how they spend their CSHS financial assistance. All CSHS' applicants receive a brief financial needs assessment that includes referrals to appropriate programs such as Supplemental Security Income (SSI), Medicaid, CHIP, and private foundations. Families are also provided education and assistance with claims information.

Each child seen at a Regional Pediatric Specialty Clinic is assessed for his/her health care coverage needs, with resource information on appropriate assistance programs, i.e. CHIP or other insurance options provided to their family. This information supports CSHS' continued efforts aimed at educating CHIP and other insurance companies as to the insurance needs of MT's CSHCN. The 2005 CSHS program data indicated that 59% of 4289 children, receiving services through the CSHS program, reported a health care payment source.

A survey gathering data about the level of Medicaid orthodontic coverage in Western MT was conducted. The survey results are being compiled, with the information expected by the end of the year.

c. Plan for the Coming Year
CSHS will continue to support plans promoting the Regional Pediatric Specialty Clinics' billing. The establishment of the third regional clinic site in Great Falls will increase children's access to services, plus their families will have access to resource information. Current efforts promoting insurance coverage for hearing aids and other uncovered services for CSHCN will be reviewed.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	0	0	71.9	72.2	72.4
Annual Indicator	NaN	71.6	71.6	71.6	71.6
Numerator	0	250	250	250	250
Denominator	0	349	349	349	349
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	72.6	72.8	72.8	72.8	72.9

Notes - 2005
For 2005 reporting, CSHS is maintaining the reporting of national survey data for continuity purposes.

Initial steps in the development of the 3rd Regional Pediatic Specialty Clinic were taken. Funding to contract with a community provider was available January of 2006. This 3rd site will provide regional access across Montana, thus assuring families of easier access to special care and coordination of follow-up at the community level. Standarized parent satisfaction surveys will be developed and conducted at this site.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
In 2005 Children's Special Health Services (CSHS) accomplished and/or initiated several projects that served to assist children and their parent's access to community based services. CSHS collaborated with a MT Office of Public Instruction Healthy Kids Committee, that provides guidance to school personnel and health care providers who serve students with health care needs in an educational environment. Throughout all of 2004 the committee met and their outcome was the January 2005 issuance of "Serving Students with Health Care Needs In Public Schools: A Technical Assistance Manual." The committee's activities and the manual are creating and strengthening partnerships between educators, parents, and health care providers.

CSHS explored multidisciplinary billing as a method of providing stable funding for Missoula's and

Billings' Regional Pediatric Specialty Clinics. Preliminary information on what multidisciplinary team billing entails was collected from Medicaid. The 2005 Legislative session granted CSHS Legislative Authority for spending billing revenue. Billing revenue would help to ensure the sustainability of clinic services and ease the financial burdens on the clinics' host hospitals, as well as to assist children and their parents in receiving needed medical services.

Tobacco tax revenue was identified as a source of funding to create a third regional pediatric specialty clinic site in Great Falls. The establishment of the clinics will begin in early 2006, after the funding is available.

A department-wide initiative was undertaken in 2004 and continued in 2005 to coordinate all Medicaid Targeted Case Management (TCM) activities. A working definition of children with special health care needs (CSHCN) was developed and approved so that the public health nurses who provide TCM services could more easily identify the children who need special services. This work resulted in the establishment of CSHCN providers' qualifications and an identified need to update the TCM Policy and Procedures manual.

CSHS' collaboration and partnership with MT School for the Deaf and Blind is progressing with the inclusion of an electronic link added to our database, CHRIS (Child Health Referral Information System). The link facilitates the tracking of the shared services for hearing impaired and vision impaired infants, children, and youth, who have been identified as CSHCN.

Parent satisfaction surveys were conducted periodically at the Regional Pediatric Specialty Clinics, and the results indicated that family were that families were satisfied with the services they received and that the clinic sites were readily accessible.

CSHS made a comprehensive change in the cleft/craniofacial clinic documentation that was provided to parents and service providers. Parents and service provider survey results indicated that both groups found the revised documents easier to read and identify recommendations.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ongoing financial support, training and consultation for Regional Pediatric Clinic Sites.				X
2. 3rd Regional Pediatric Clinic Site (to complete regional clinic coverage) developed.			X	X
3. Develop electronic link with Montana School for the Deaf and Blind (MSDB) to facilitate tracking/shared services for hearing and vision impaired infants, children, and youth.				X
4. Revise cleft/craniofacial documentation to standardize and faciliate reporting.			X	
5. Assist the Office of Public Instruction (OPI) with revising Montana's technical assistance manual for serving students with health care needs in the educational environment.				X
6. Pursue and implement legislative authority to spend clinic billing money to support Regional Pediatric Specialty Clinic Sites.				X
7. Continue work Medicaid Targeted Case Management (TCM) for CSHCN, including developing a working definition of CSHCN and establishing qualifications of CSHCN TCM providers.				X
8.				
9.				
10.				

b. Current Activities
The Regional Pediatric Specialty Clinic Programs (RPSCP) continue to actively provide services to Montana's CSHCN. The existing Regional Pediatric Specialty Clinic Sites continue to receive CSHS financial support, training, and consultation. Parent Satisfaction Surveys are collected at periodic intervals at the two clinics. The survey results indicate that families are pleased with the services they receive and that the clinic sites are readily accessible. It is anticipated that the multidisciplinary team billing, discussed in PM #4, will contribute to the clinic sites being readily accessible.

A Request For Proposals (RFP) was released in the Fall of 2005 for the third Regional Pediatric Specialty Clinic Site, and the Great Falls Clinic receiving the contact in April. The Great Falls site has recently hired a nurse/clinic coordinator who is currently receiving orientation. CSHS is providing consultation with the new coordinator and clinic staff to assist in development of the new clinic. The Great Falls site will also be conducting Parent Satisfaction Surveys.

The electronic data link between the CSHS data system, CHRIS, and the Montana School for the Deaf and Blind (MSDB) has been completed and is ready for user testing, tentatively scheduled for the end of July 2006. This link will facilitate the tracking of the shared services for hearing and vision-impaired infants, children, and youth. MSDB's use of CHRIS was delayed to allow the Universal Newborn Hearing Screening Task Force time to describe a system of care for children born with hearing loss or deafness. The system of care description will help the CSHS-MSDB link to be used more strategically and effectively.

January 2006 marked the debut of the CSHS web-site, www.cshs.mt.gov. The site provides families, providers and others with information about CSHS, pediatric clinics, resources, and links to web-sites.

c. Plan for the Coming Year
CSHS will continue its commitment to use MCH funds to assist uninsured and underinsured CSHCN in accessing multidisciplinary clinics. Additional Legislative authority will be requested for this activity during the 2007 Legislative session. CSHS plans to facilitate a collaborative meeting with representatives of the regional clinic sites, with the goal to develop a plan for clinic expansion so as to provide additional clinic services in Montana.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			6	6.5	6
Annual Indicator		5.4	5.4	5.4	5.4
Numerator		8	8	8	8
Denominator		147	147	147	147
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	6	6.5	6.5	7	7

Notes - 2005
No change has been made in the data from previous year.
Transition issues are addressed for all youth aging out of Regional Pediatric Specialty Clinics

services and CSHS addresses transition of health care for youth aging out of the CSHS financial assistance program.

During the 2004-2005 school year 944 students graduated from regular high school with an active IEP, which is required to contain transition information. The degree of health transition information included in IEP's is undefined. CSHS plans to work with OPI and other community and state agencies to determine how best to participate in inclusive transition planning.

Targets reviewed - no change made.

Notes - 2004
No change has been made in the data from the previous year.
The TA was requested. Transition issues are continually discussed on a provider to family basis regarding the appropriate developmental stages. CSHS has established a collaborative relationship with the Office of Public Instruction and Vocational Rehabilitation with a goal of exploring how this information might be obtained and how to improve transition services.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

a. Last Year's Accomplishments
Children's Special Health Services (CSHS) continues to provide limited support to youth who receive CSHS financial assistance for medical care regarding health insurance, procuring pharmaceuticals/ prescription drugs, and selecting adult specialists.

CSHS collaborated with Vocational Rehabilitation Services for an educational presentation for parents, providers and CSHS staff on their available services and resources. Additional collaboration opportunities exist with developmental disability providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide limited support to youth receiving financial assistance for Children's Special Health Services (CSHS) and at regional clinic visits regarding health care transitions .		X		
2. Provide a Vocational Rehabilitation presentation at an annual mini conference on autism.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CSHS staff participated in a Connecting for Kids Committee, a state health department based committee formed to discuss children's health issues, which worked to describe transition issues across the spectrum of development. Information was provided to DPHHS management staff in anticipation of further direction for committee members.

CSHS continues to work with program partners such as Family Voices and parent training/advocacy groups in the development of a multi-stage transition plans.

c. Plan for the Coming Year
A feasibility study exploring the fiscal impact of increasing the age limit for financial assistance to age 22 for CSHCN with chronic conditions, i.e. cystic fibrosis is planned.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	90	90	90	90	91
Annual Indicator	91.6	90.7	89.7	90.9	91.9
Numerator	9809	2610	2440	2603	2568
Denominator	10709	2878	2721	2864	2793
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	80	80	80	80	80

Notes - 2005
The data for this performance measure are collected using an immunization survey, which samples public and private immunization providers throughout the state. The data were collected from 53 of the 56 counties, including Tribal and IHS clinics, and represent 25% of the birth cohort. The survey only collects data on children ages 24-35 months. The policy of the Montana immunization program is to only consider children to be late in receiving all age-appropriate vaccinations when they have reached 24 months. While they do evaluate coverage at 19 months, they only asssess actual coverage and lack of coverage among 24 month-olds and older.

The state recently implemented an electronic immunization registry. This registry is expected to provide population-level data on Montana's immunization rates within the next several years as reporting improves and links with vital statistics data are developed.

The numerator represents the number of children assessed by the survey who were appropriately immunized. The denominator represents the number of children assessed.

The immunization rate refers to the series combination of 4 DTaP: 3 Polio: 3 Hib: 1 MMR: 3 Hep B. For 2005, the 4:3:3:1:3 rate was 91.9%, exceeding our objective.

During the next year, varicella will be added to the required vaccine regimen. Because of this change, the immunization rate is expected to drop, then gradually increase as varicella vaccination rates increase.

a. Last Year's Accomplishments
Immunization rates: Statewide vaccination rates (series combination of 4 DTaP: 3 Polio: 3 Hib: 1 MMR: 3 Hep B) for children aged 24-35 months of age, seen in public and private vaccine provider clinics in Montana during 2004

The data were collected from 53 of the 56 counties, including Tribal and IHS clinics, and represents 25% of the birth cohort.

The "Reading Well" collaborative project with Medicaid and the Office of Public Instruction continued last year. This collaborative project allows families of 2 year old children or pre-kindergarten children, who bring the completed immunization record in for entry into the statewide immunization registry, to choose a book from "the reading well." This incentive project helps to populate the immunization registry, which gives Medicaid a more complete assessment tool, and encourages families to read with their children.

The State rolled-out an electronic reporting and tracking system for immunizations to be used by providers throughout the state.

Group and family daycare centers in 19 Montana counties were assessed by a local public health nurse to determine the number of children with age-appropriate (and those required by the Administrative Rules of Montana) vaccinations. 939 children's records were assessed, and 84% of the records documented up-to-date immunizations.

Revision of the administrative rule improved the Montana immunization requirements for school attendance. The administrative rule was changed to require the 2nd MMR prior to kindergarten attendance, and proof of a Td containing vaccine booster prior to entrance of grade seven. The second MMR prior to kindergarten attendance went into effect in 2005.

The Administrative Rules of Montana (ARM) were altered to add varicella to the list of reportable diseases.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Contract with county health departments for maintenance of statewide immunization registry.			X	
2. Distribute VFC vaccines to providers registered with the Vaccines for Children Program in Montana from 54 counties and 7 tribal health jurisdictions.			X	
3. Contract with the county health departments to assess immunization records of children in the day care settings.			X	
4. Contract with the county health departments to assess the school immunization record of kindergarten students and grade 7 students.			X	
5. Contract with the county health departments to provide educational services to staff in private clinics in their health jurisdictions regarding immunization.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Revision of the administrative rule improved the Montana immunization requirements for school attendance. The administrative rule was changed to require the 2nd MMR prior to kindergarten attendance, and proof of a Td containing vaccine booster prior to entrance of grade seven. The second MMR prior to kindergarten attendance went into effect in 2005, and the Td containing booster will go into effect at the beginning of the 2006 school year.

Baseline year for 2nd MMR prior to kindergarten was 2004. During that year, 81.43% of kindergarten children had proof of their 2nd MMR prior to school entry.

Following revision of the administrative rule, in 2005, 99.8% of the kindergarten students from 99% of the kindergartens in Montana were appropriately immunized with 2 MMRs, showing an increase of > 17%.

The program will continue to support and monitor the electronic immunization registry and contract with county health departments to maintain it. The program is working on incorporating birth certificate data into the system so that all children born in Montana are included in the immunization tracking.

The Immunization Section will work with the Daycare Licensing Bureau to revise the immunization requirements for children attending a daycare facility in Montana. We have already added proof of disease or proof of vaccination by 19 months of age for children attending daycare. The Section will also contract with the county health departments to assess and report on the immunization records of children in the day care settings and assess the school immunization record of kindergarten students and grade 7 students.

A booster dose of Tetanus and Diphtheria containing vaccine (which we hope will be TdaP) will be required for entry to grade 7 for the 2006-2007 school year.

The Montana Immunization Section will continue to distribute VFC vaccines to providers registered with the Vaccines for Children Program in Montana from 54 counties and 7 tribal health jurisdictions.

c. Plan for the Coming Year

1) Decrease varicella disease in Montana by increased surveillance and improving immunization rates.

The new communicable disease rules for Montana have added chickenpox (varicella) to their list of reportable diseases. Next year, varicella will be added to the list of antigens in the series combination for evaluation in the provider practices, i.e., 4 DTaP: 3 Polio: 3 Hib: 1 MMR: 3 Hep B: 1 Varicella. The addition of varicella is expected to result in a drop in the percent of children who receive age-appropriate immunizations by age two. However, as providers incorporate varicella into the regimen, the percent of children covered is expected to increase again.

2) The Immunization Section will continue to work with the Daycare Licensing Bureau to revise the immunization requirements for children attending a daycare facility in Montana.

3) Decrease the number of adolescents susceptible to pertussis disease in Montana.

As mentioned above under current activities, a booster dose of Tetanus- and Diphtheria-containing vaccine (which we hope will be TdaP) will be required for entry to grade 7 for the 2006-2007 school year. The immunization law for schools specifically states a person over the age of 7 years is not required to have pertussis immunization. That law was based on 20 year old information about vaccines, and will have to be changed. The rule must reflect the intent of the law, so the State cannot mandate the TdaP with the pertussis component before the language in the law is changed.

4) Continue to provide education for medical professionals regarding surveillance for pertussis cases, contact investigation and recommended prophylaxis.

5) The Immunization Section will continue to contact with county health departments to maintain

the electronic immunization registry. With the implementation of the registry, the state immunization program plans to be able to provide population-based data on immunization rates throughout the state.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	19	19	18.5	18	15
Annual Indicator	17.6	17.4	15.4	9.8	9.7
Numerator	377	373	330	349	347
Denominator	21378	21378	21378	35744	35744
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	9.6	9.6	9.5	9.5	9.3

Notes - 2005
Denominator data came from the 2004 Census Population estimates for 15 to 17 year old girls in Montana.

Notes - 2004
Denominator data came from the 2004 Census Population estimates for 15 to 17 year old girls in Montana.

Notes - 2003
Denominator data is of an unknown source.

a. Last Year's Accomplishments
The Montana Department of Public Health and Human Services (DPHHS) includes the prevention of teen pregnancy as one of its key issues in public health. In 1997 the state Legislature mandated a 10% reduction in the state's 5-year teen pregnancy rate by the end of the 1999 biennium, although no additional funds were allocated. Data show that from 1999 to 2004 there was a 12.5% reduction in the birth rate for teens ages 15-17.

The Women's and Men's Health Section (WMHS) fills a leadership role in teen pregnancy prevention efforts for the Department. The WMHS Health Educator acts as the Department's Teen Pregnancy Prevention Coordinator. The WMHS is currently exploring new ways to integrate teen pregnancy prevention efforts into its program and the Department. Strategies under consideration include participating in The National Campaign to Prevent Teen Pregnancy‘s "Setting Teen Pregnancy Rates Reduction Goals" -- a national effort to set the teen pregnancy prevention agenda for the next decade and create a statewide teen pregnancy prevention coalition.

The WMHS Program Specialist acts as a key resource for the collection and dissemination of teen pregnancy data. The Trends in Montana Teen Pregnancies and Their Outcomes From 1981 - 2000 report is in the process of being updated. The updated tables are available to be distributed to local family planning clinics, county health department personnel, media contacts, public policy makers, and university students. Recent analyzed 2004 data shows that the five year (2000-2004) teen pregnancy rate continues to drop for 15-19 year olds and is currently 48.9/1,000. This represents a 16.3% reduction from the 1993-1997 rate of 58.4/1,000.

The Montana Title V Abstinence education project is now located in the Family and Community Health Bureau, Public Health and Safety Division. Montana's Title V Abstinence grant has been

re-structured to distribute abstinence monies to local county health offices and tribal governments through the MCH contracting process. Local entities may choose to either accept or return the monies at their discretion. Monies are allocated based on the MCH funding formula. Currently, 11 eligible entities have accepted the Title V Abstinence funding for fiscal year 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In State Fiscal Year (SFY) 2007, contract with 15 agencies with services in 29 clinic sites for reproductive health care, including funding for high-cost contraceptives.				X
2. In SFY 2007, at least 28% of FP clients served by local clinics will be 19 year and under.	X			
3. In SFY 2007, 100% of local clinics will outreach to youth at high risk of teen pregnancy and birth.			X	
4. In SFY 2007, the FP Education Committee will assess and coordinate training as needed for local clinic staff through a minimum of 8 conference calls.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Women's and Men's Health Section (WMHS) contracts with agencies statewide to provide family planning and reproductive health care. Special funds are allocated for high-cost and efficacious contraceptives. Almost one-third of clients served are teenagers and outreach is conducted to teens because they are considered at high risk for teen pregnancy and birth. In order to better serve the teen population and reduce the risk of unintended pregnancy and teen births, the Education Committee assesses and coordinates training as needed for local clinic staff.

WMHS is beginning the process of updating its "Trends in Teen Pregnancy Report," last updated in 2002. Once completed, the "Trends in Teen Pregnancy Report" will be distributed to local partners focusing on teen pregnancy and teen birth rates, including local health departments, Women, Infants and Children (WIC) agencies, Offices of Public Assistance, school districts, Public Health Home Visiting projects, Indian Health Service clinics, media contacts and public policy makers. A copy of the report will be made available on the DPHHS web site.

Educational materials on teen pregnancy prevention are distributed by WMHS staff to local family planning programs, constituents, students, midwives, school nurses and public health contacts. Annually, WMHS updates the Unintended Teen Pregnancy Fact Sheet for use with legislators, local teen pregnancy coalitions, public health professionals and within DPHHS.

Special funds were received during State Fiscal Year (SFY) 2006 to serve high-risk and targeted populations--such as teens. The WMHS applied for and received special grant funding for local Male Adolescent Clinics; Information, Education and Communication (IEC) projects; Client, Family and Community Involvement (CFC); Strategic Referrals and Contraceptives and Technology. Local male clinics use teen male interns to reach an increased number of male clients. The IEC projects fund local clinics to increase awareness of family planning services and to increase knowledge on reproductive health. The CFC projects focus on outreach to special

needs populations, parents and school districts to increase awareness and support for family planning services. The Strategic Referrals project will improve community collaboration and partnerships to enhance service delivery. Through special funds for Contraceptives and Technology, WMHS can support highly effective contraceptives, including emergency contraceptives, thereby reducing teen pregnancy rates as well as the teen birth rate.

c. Plan for the Coming Year

The Women's and Men's Health Section (WMHS) will facilitate community acceptance of and access to family planning services and counseling for clients of all ages. The WMHS will contract with 15 delegate agencies to provide family planning services in 29 locations throughout Montana. In working toward this goal with local clinics, the WMHS will continue to assure the active and continued involvement of family and community in the provision of family planning services to those in need.

Local clinic staff will continue to participate in the State Family Planning Education Committee facilitated by the WMHS Health Educator. One focus area of this committee is teen pregnancy prevention and addressing the training needs of local clinic staff. A needs assessment is conducted annually for local staff to assess training needs.

The WMHS has applied for strategic initiative funding in SFY 2007 that supports targeted projects to expand services to an underserved community (Big Sky, MT), improve community teen pregnancy prevention partnerships (Bozeman, MT), and improve and expand access to family planning services within urban Indian populations (Billings, Butte, Great Falls, Helena, Missoula). All three of the strategic initiative proposals address the HP 2010 goal to reduce the rate of unintended pregnancy, and two of the proposals directly target reducing pregnancies among adolescent females.

The WMHS will continue to provide special funding for efficacious contraceptives to local family planning clinics.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	39	40	41	42	40
Annual Indicator	2.0	5.2	13.0	41.6	33.2
Numerator	258	668	1683	4283	3413
Denominator	12907	12907	12907	10295	10295
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	40	40	40	40	40

Notes - 2005

For 2004 estimates, oral health convenience data was utilized. Prior to 2004, estimates were derived from Medicaid data only. For 2005 estimates, a random oral health sample was collected. Data percentages extracted from the random sample were utilized to extrapolate the numerator applicable for this measurement, as the random sample was only a proportion of the target population.

Notes - 2004

Sealant assessment for 2004 was evaluated via convenience sampling of volunteer schools throughout the state. The rate is calculated using a crude prevalence with weights calculated and applied based on regional 3rd grader population totals obtained from the Office of Public Instruction (OPI). However, when the data was regionally stratified and weights were applied by region, 2004 weighted data contained an outling region over two standard deviations from the mean, causing significant skewness of the results (with over a 10% difference). Therefore, the calculation reported here contains only 4 regions, as the outlier region was purposefully extracted from the dataset.

Notes - 2003
The numerator and denominator data for this NPM have been changed for all years to reflect the correct number of third grade children who have received protective sealants on at least one permanent molar tooth in relationship to the US Census counts of the entire population of Montana 8 year olds.

a. Last Year's Accomplishments
For the school year 2005-2006, a statewide stratified, random sample of elementary public schools was generated for collection of oral health data on 3rd graders throughout the state of Montana. The stratified sampling scheme utilized free and reduced lunch as the defining criteria, with the mean proportion of free/reduced lunch in the state as the criteria line. Thirty schools were then randomly selected, 15 schools from each stratification level. Information collected included past carie info, present untreated carie info, sealant info, and treatment info. Race, gender, and age designations were also collected. Screenings were performed by three contracted dental hygienists who had standardized national protocol training. Results from the sample are representative of the state's 3rd grader population and can be utilized at the national level for comparison at the state level. Additionally, while the hygienists were at a given local, Head Start programs were contacted and screenings on preschool children were performed. Gathered information was generally the same, except for sealant information was not collected and Early Childhood Caries (ECC) information was collected.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to monitor 3rd grader sealants in the public school system through the volunteer-only convenience sample.			X	X
2. Analysis of the controlled stratified-random sample should incorporate results by demographic data, including race, gender, geographical location, and others.			X	X
3. Promote and disseminate information to schools and other stakeholders as to the benefits of sealants by age 8 (3rd grade).			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Screenings on third graders and Head Start preschoolers throughout the state have been completed. Preliminary results have been analyzed with weights according to stratification levels calculated and applied to the sampled proportions. Preliminary results for the third grader data were disseminated to stakeholders and bureau chiefs/section managers. Data has also been utilized for MCHBG reporting.

c. Plan for the Coming Year
Analysis of the data will continue to include analysis of Head Start data, analysis of 3rd grader and Head Start data by race, free/reduced lunch, gender, and geographical location. Results should help develop program initiatives, as well as redirect supplies/funding of MCH monies to appropriate areas.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	4.9	4.8	4.7	4.6	4.5
Annual Indicator	5.9	5.4	4.3	5.8	5.8
Numerator	11	10	8	10	10
Denominator	186130	186130	186130	172126	172126
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	4.4	4.3	4.2	4.1	4

Notes - 2005
Denominator data came from the 2004 Census Population estimates for children ages 0 to 14 years of age in Montana. Numerator data came from vital stats.

Despite the disparity between the indicator and objective, Montana is retaining the aggressive objective for this PM.

Notes - 2004
Denominator data came from the 2004 Census Population estimates for children ages 0 to 14 years of age in Montana. Numerator data came from vital stats.

a. Last Year's Accomplishments
The Montana Legislature passed several bills that are expected to affect motor vehicle deaths, including SB 104, establishing the Graduated Driver's Licensing (GDL) program for all new teen drivers; SB 38, doubling fines in school zones; SB 80, which prohibits open alcohol containers in vehicles. Fetal, Infant, and Child Mortality Review (FICMR) and death record data were used to support the need for these legislative changes.

On July 1, 2006 the Graduated Drivers License (GDL) became a law in Montana. GDL is a three-phase system for beginning drivers, consisting of a learner's permit, a provisional (or intermediate) license, and a full license. A learner's permit allows driving only while supervised by a fully licensed driver. A provisional license allows unsupervised driving under certain restrictions. These usually include limits on driving at night or with teenage passengers. The learner's permit and the provisional license each must be held for a specified minimum period of time before a driver receives a full license.

The Child, Adolescent and Community Health (CACH) Section of the Montana Department of Public Health and Human Services (DPHHS) continued to act as a team member on the ambulance/emergency room/payment feasibility data linkage project.

The Adolescent and School Health Consultant became a member of the State FICMR team.

Data from Fetal, Infant and Child Mortality Review (FICMR) teams indicate 65 infants and

children and one fetus died due to a motor vehicle crash (MVC) in 2003-2004. Nineteen of the drivers at fault were less than 16 years of age, while four were less than 15 years of age. Six of the 11 reviews also cited alcohol and/or drugs as a contributing factor to the motor vehicle-related fatality. In 31 of the MVC fatalities a seatbelt was present in the vehicle but it was not being used at the time of the crash.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Child, Adolescent and Community Health (CACH) section staff will continue to advocate legislative efforts to decrease motor vehicle deaths by supporting the primary seatbelt law (which establishes not wearing a seatbelt as a primary offense) and othe				X
2. CACH staff will support stronger legislation on driving under the influence (DUI) through research and analysis of data relating to death and injury from motor vehicle crashes involving alcohol.				X
3. The Adolescent and School Health Coordinator will work with the Joint Committee for Healthy Kids, Connecting for Kids and the State Fetal, Infant and Child Mortality Review (FICMR) team to research strategies for further reducing alcohol-impaired dri				X
4. CACH staff will research and promote social marketing techniques to educate opinion leaders and the public about the causes of motor vehicle-related injuries and effective personal safety practices.			X	
5. The FICMR Coordinator will continue the collection, analysis, and dissemination to partners and the public of FICMR data relating to motor vehicle crashes.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CACH continues to support legislative efforts to improve safety via advocating for primary seatbelt laws.

CACH continues to pursue stronger legislation regarding driving under the influence of drugs and alcohol (DUIs).

The Adolescent and School Health Coordinator is working with the Joint Committee for Healthy Kids (JCHK), Connecting for Kids and State FICMR team to research strategies for further reducing alcohol-impaired driving.

The FICMR Coordinator is exploring and promoting social marketing techniques to educate opinion leaders and the public about the causes of motor vehicle-related injuries and effective personal safety practices.

The February 23, 2006 FICMR state team meeting focused on motor vehicle crash deaths. This resulted in FICMR becoming involved in a collaborative effort with the Department of Transportation (DOT), Office of Public Instruction (OPI), Healthy Mothers Healthy Babies, the Montana Highway Patrol, and the National Center for Injury Prevention and Control to explore

preventative measures for reducing motor vehicle crashes and resulting injuries within Montana.

c. Plan for the Coming Year
Coordinate with FICMR, JCHK and OPI Driver's Education Program to support legislative efforts for Graduated Drivers Licensing (GDL), stronger DUI legislation, seatbelt safety, and open container laws.

Promote public education and awareness of the new GDL law by producing two press releases supporting the law and its intended purpose of instructing Montana youth in safe driving skills.

Provide support for and promotion of parental use of seatbelts through two press releases.

Increase collaborative efforts between DPHHS, DOT, OPI, Healthy Mothers Healthy Babies, Montana Highway Patrol, and the National Center for Injury Prevention and Control, to explore preventative measures for reducing motor vehicle crashes and resulting injuries in Montana.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					25.9
Numerator					3184
Denominator					12283
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	26	27	27	28	28

Notes - 2005
These data are from the WIC program, which provides the best estimate of breastfeeding rates among mothers in Montana. The denominator includes all children under two years of age enrolled in WIC during 2005. The numerator reflects all children enrolled in WIC whose mothers reported breastfeeding them at 6 months of age.

For a historical perspective on this performance measure, see state performance measure 3.

a. Last Year's Accomplishments
A new chapter focusing specifically on breastfeeding promotion and support was added to the Montana WIC State Plan. This chapter (Chapter 7) consolidates all of the breastfeeding-related information which was previously scattered throughout the state plan and establishes breastfeeding as an area of focus.

Two Native American Breastfeeding Posters were developed and distributed to all clinics.

Montana received a Peer Breastfeeding Counseling (PBC) grant. This grant is US Department of Agriculture (USDA) funding to establish peer counseling programs throughout the state. The funding is used to hire and train peer counselors to support mothers in increasing the duration of breastfeeding. The peer counseling method has been found to be the best way to increase and initiate breastfeeding. Ravalli County WIC was awarded the Pilot Peer Breastfeeding Counseling Grant. Three of their staff were sent to the peer breastfeeding counselor training in Denver

offered by USDA in conjunction with Best Start.

A week-long breastfeeding conference, the Lactation Counselor Certificate Training Program, was held for WIC staff. Participant slots not filled by WIC staff were opened to other interested health care providers. Upon completion of this training, participants who passed the final test receive a Certified Lactation Counselor (CLC) certificate. Continuing education is required to maintain the certificate. Breast pumps and breastfeeding education materials continue to be purchased by the State Office and disseminated to local programs. Information on free breastfeeding posters and pamphlets from the National Breastfeeding Awareness Campaign, updated information on breastfeeding recommendations from the American Academy of Pediatrics, pertinent news and information/studies on breastfeeding, and information on free breastfeeding pamphlets in Spanish were distributed to local programs.

Lactation Education Funds were used to purchase lactation self-study modules, to provide another avenue of training for local WIC Program staff and to address the CEU needs for the CLC. Activities performed by local programs during World Breastfeeding Week were shared. Montana sponsored the International Board Certified Lacatation Consultant (IBCLC) registration of two local agency staff.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue distribution of manual and electric breast pumps to local WIC agencies.		X		
2. Continue to provide early pre-hospital breastfeeding education to WIC parents.			X	
3. Purchase breast feeding reference book for pregnant women and new breastfeeding mothers.			X	
4. Continue Peer Breastfeeding Counselor Projects through local WIC agencies.			X	
5. Support local WIC staff with continuing education unit modules for certified lactation counseling and additional training.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Ravalli County WIC Program received a subsequent Breastfeeding Peer Counselor Grant from the State Office after completing the pilot project. The Pilot Peer Breastfeeding Counseling Grant was evaluated and expanded to other local programs. Four other programs were offered to apply for projects. Two have completed an application and will be receiving funds for the remainder of the year.

Breastfeeding education materials for participants were distributed to local programs. Breast pumps continue to be distributed. A new electric single-user breast pump was distributed to select local programs for review.

The Breastfeeding Coordinator joined with other interested parties in the state to form a Statewide Breastfeeding Coalition (initiated by the Nutrition and Physical Activity Program). Breastfeeding education materials were purchased and distributed to local programs. Several items were purchased in Spanish, limited other languages or with emphasis on other ethnic

groups.

The new chapter in the Montana WIC State Plan, Chapter 7 "Breastfeeding," was distributed to all local programs.

At the Spring Public Health Conference new local staff were offered a hands-on opportunity to examine and assemble all of the current models of breast pumps. A session on the emerging role of breastfeeding in the prevention of obesity and diabetes was presented. In August, the Missoula Nutrition Resources is sponsoring "The Lactation Counselor Certificate Training Program--A comprehensive breastfeeding management course". A number of local staff have registered to attend.

The Breastfeeding Coordinator attended "Using Loving Support to Build a Breastfeeding-Friendly Community" and the U.S. Breastfeeding Committee's "National Conference of State Breastfeeding Coalitions".

c. Plan for the Coming Year
Continue the Peer Breastfeeding Counselor Projects, offering to select local programs the opportunity to initiate and operate a project.

Expand the Peer Breastfeeding Counselor Projects with one or two additional sites, concentrating on smaller programs with fewer local resources to support breastfeeding.

Continue to purchase breastfeeding education materials that have been selected to provide standardized breastfeeding education materials, including in other languages and targeted to other racial groups.

Participate in the Statewide Breastfeeding Coalition.

Encourage local programs to participate in World Breastfeeding Week and to share their activities.

Evaluate the use of the lactation self-study courses. Local program staff will be surveyed as to use of the modules toward Certified Lactation Counselor (CLC) continuing education credits. If local staff did not utilize the modules or maintain CLC status, the modules will not be purchased with funds from the State Office.

Evaluate if funding is available and plan another week-long training for local program staff to attend "The Lactation Counselor Certificate Training Program--A Comprehensive Breastfeeding Management Course" or more advanced breastfeeding training.

Continue to purchase and distribute breast pumps to local WIC agencies.

Investigate the feasibility of a sole-source bid for breast pumps from the manufacturers and consider the effects of the resulting limited selection.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005

Annual Performance Objective	80	98	98	98	98
Annual Indicator	83.3	90.1	90.0	92.8	87.9
Numerator	9111	9810	10144	10563	10157
Denominator	10935	10886	11276	11378	11551
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	92	92	92	92	92

Notes - 2005
Preliminary birth cohort for Montana in calendar year 2005 is 11,551.

Reset the objectives for 2006 to 2010 to address the issue of early discharge which impacts testing.

a. Last Year's Accomplishments
Montana has a voluntary newborn hearing screening program. In 2005, 31 of the 33 hospitals providing obstetric services participated in the statewide screening effort with varying degrees of completeness. As a result, 92% of the 11,551 babies born in calendar year 2005 were screened, 88% of them before hospital discharge. Seven (7) of the babies included by the hospitals in the reporting software (HI*TRACK) were identified as being deaf or hard of hearing -- four (4) with permanent congenital hearing loss and three (3) with fluctuating conductive hearing loss. Based on expected occurrence in a standard population of 1 per 1,000 births, Montana expected to have 12 babies diagnosed as deaf or hard of hearing in 2005.

In the spring of 2005, an attempt was made to electronically match a sample of birth certificate data with hearing screening data. It was discovered that too few of the required matching data elements were being recorded in HI*TRACK to allow satisfactory matching of babies' records with their birth certificates. The decision was made to focus instead on matching birth certificate data with mandatory newborn bloodspot testing data and then match those results with the hearing screening data.

In November of 2005, a three-month series of facilitated meetings were held with Newborn Hearing Program staff and the Universal Newborn Hearing Screening and Intervention (UNHSI) Task Force -- a statutorily created advisory group charged with the responsibility to make recommendations to the department on specific issues. The Task Force recommended that newborn hearing screening become mandatory and that Administrative Rules be developed to specify the procedures to be carried out by all birthing facilities, midwives and audiologists in the state to ensure complete and accurate reporting.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Link newborn hearing screening data with matched newborn bloodspot testing data and Birth Certificate data.				X
2. Continue to contract for Help Desk technical assistance for use of the tracking software by birthing facilities and audiologists.				X
3. Track newborn hearing screening and audiological assessment results from the tracking software and communicate results to screening and assessment partners statewide.			X	
4. Electronically refer infants diagnosed as deaf or hard of hearing to the Montana School for the Deaf and Blind within six months of each child's birth.		X		
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Early in 2006, the Newborn Hearing Screening Program staff prepared amendments to the enabling legislation creating the statewide voluntary screening program. The amendments make the statewide program mandatory for all hospitals and facilities providing obstetric services and require reporting of audiological assessments of all babies who do not pass their screenings. It is anticipated that Administrative Rules implementing the statewide program will be developed with public input following the completion of the state legislative session that begins in January 2007.

The Newborn Hearing Screening Program manager met again with staff of the Office of Public Instruction (OPI) and the audiologists who contract with OPI to perform Child Find activities under the state-supported Hearing Conservation Program (HCP). The HCP audiologists have agreed to work with birthing facilities in their service regions across the state to ensure that babies who did not complete their screening before hospital discharge are rescreened at no cost to their parents. The HCP audiologists will also facilitate referrals for pediatric audiologic assessments for those babies who do not pass their screenings. It is anticipated that this collaborative effort will increase the number of babies who complete their screenings by one month of age, and the number of babies who receive needed audiologic assessment by three months of age.

The Newborn Hearing Screening Program manager is working with birthing facilities to encourage efficient reporting of mother's maiden name in HI*TRACK to facilitate the automated matching process with the data that will be derived from matching newborn bloodspot screening with birth certificates.

c. Plan for the Coming Year
The major plans for new activities in 2007 are: facilitate the passing of amendments to the enabling legislation that will make newborn hearing screening mandatory and will require reporting of audiological assessment results for all babies who do not pass their screenings; promulgate Administrative Rules to implement the mandatory program; automate the matching of birth certificates and both newborn hearing and bloodspot screenings; and perform a feasibility study on implementation of a web-based tracking system for newborn hearing screening. The completion of these activities is expected to improve the ability of the Newborn Hearing Screening Program staff to provide timely and accurate feedback to screening and audiologic assessment partners across the state. Once each baby has been identified as deaf or hard of hearing, the Montana School for the Deaf and Blind (MSDB) is statutorily responsible for tracking the interventions for that child. The Newborn Hearing Screening Program and other Children's Special Health Services staff have already collaborated with MSDB to electronically link HI*TRACK data with the Children's Health Information and Referral System (CHRIS) data system that will be used by MSDB to track those interventions. Such collaboration among statewide partners will allow Montana to reach its "1-3-6" goal -- screenings completed by one month of age, necessary audiologic assessments completed by three months of age, and appropriate intervention by no later than six months of age.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005

Annual Performance Objective	11	17	16	16	9
Annual Indicator	18.0	17.0	17.0	17.0	17.0
Numerator	46340	39207	38755	38755	38755
Denominator	257440	230630	227972	227972	227972
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	16	16	15	15	15

Notes - 2005
The numerator for this performance measure is based on the 2003 Montana Household Survey, which asked about insurance among youth ages 18 years and younger. The survey results indicated that 17% of Montana's children were uninsured. Montana's CHIP program uses this survey as its estimate of uninsured children in the state. The denominator is the 2003 census estimate for children 18 years of age and younger.

The Current Population Survey, conducted by the US Census Bureau, is an alternative source of information for this performance measure. In 2005, it estimated that 19.5% of children 0-17 in Montana were without health insurance coverage. However, the number of households surveyed (78,000 nationwide) is small and so this survey is used only as a comparison.

The target of 9 for 2005 was unrealistic and was reset prior to MCHBG initial submission.

Notes - 2004
The numerator for this performance measure is based on the 2003 Montana Household Survey, which asked about insurance among youth ages 18 years and younger. The survey results indicated that 17% of Montana's children were uninsured. Montana's CHIP program uses this survey as its estimate of uninsured children in the state. The denominator is the 2003 census estimate for children 18 years of age and younger.

Notes - 2003
The numerator for this performance measure is based on the 2003 Montana Household Survey, which asked about insurance among youth ages 18 years and younger. The survey results indicated that 17% of Montana's children were uninsured. Montana's CHIP program uses this survey as its estimate of uninsured children in the state. The denominator is the 2003 census estimate for children 18 years of age and younger.

a. Last Year's Accomplishments
The results of the Montana Statewide Study of the Uninsured State Planning Grant conducted by the Department of Public Health and Human Services found that 17% of Montana children age 0-18 were uninsured. The information was obtained through research, surveys, focus groups, key informant interviews and public meetings. There are 22,000 Montana children who live in households with incomes at or below 150 percent of the Federal Poverty Level. Approximately one-third of these children may be eligible for Medicaid. Therefore, approximately 15,000 children could be eligible for CHIP.

CHIP provided health insurance coverage for 15,841 Montana children in FFY 2005. The annual CHIP Enrollee Survey indicates a high level of satisfaction with CHIP. The areas of focus include the following: Customer Service, Child's Personal Provider, Child's Health Care, Child's Dental Care, Timeliness of Care, and Provider Communication. We strive to maintain and improve our network of CHIP providers to ensure access to health care for children with CHIP. At the end of FFY 2005 there was a CHIP provider network of 252 dentists and 3,474 physicians, allied health providers and hospitals throughout Montana. This provider network continues to grow steadily and ensures access to health care for children with CHIP coverage.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Acquire state and local funds to match federal funds and continue to insure Montana children.				X
2. Refer 100% of children not eligible for CHIP to other appropriate programs or plans.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

At the end of FFY 2005 there were 11,500 children enrolled and no waiting list. Currently, there are more than 13,000 children enrolled in CHIP. The program continues to receive solid support from Governor Schweitzer, the legislature, families with CHIP coverage and the general public.

CHIP screens all applications for Medicaid eligibility and forwards all applicants who appear potentially eligible for Medicaid to local public assistance offices. We provide information about the Caring Program for those children found to be over income for CHIP. The program refers to and coordinates with Children's Special Health Services and Children's Mental Health Services.

The program sends information about the Primary Care Association members (Community Health Centers, National Health Service Corps sites, Migrant and Indian Health clinics) to all families who apply for CHIP.

CHIP also provides information and referrals to Blue Care, Montana Youth Care and Montana Comprehensive Health Association. Callers to the Department's Family Health Line can also receive resources and referrals to private, low-cost health insurance and other resources in their communities.

The program conducts visits to each Native American tribe in Montana to provide information and answer questions regarding CHIP.

In March 2006 CHIP began offering an extended plan of mental health benefits for children determined to have serious emotional disorders (SED). The CHIP Extended Plan covers the following community-based mental health services: therapeutic group home services (including room and board); therapeutic family services; day treatment; community-based psychiatric rehabilitation and support services; individual and family counseling sessions; and respite care.

c. Plan for the Coming Year

CHIP will continue to provide quality, comprehensive insurance coverage for Montana children. The projected enrollment for FFY 2007 is 13,900 children at or below 150% of the federal poverty level (FPL). The state may self-administer CHIP instead of purchasing a fully insured product from Blue Cross Blue Shield of Montana. A request for proposal (RFP) has been issued and a decision regarding self-administration will be made prior to the beginning of FFY 2007.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					26.6
Numerator					3447
Denominator					12936
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	25	25	24	23	22

Notes - 2005
The reported denominator includes all children ages 2-5 enrolled in WIC during 2005. The numerator reflects all children with risk codes 16 and 17.

a. Last Year's Accomplishments
New performance measure in 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Work to achieve Goal 4 of the MT Nutrition and Physical Activity State Plan to Prevent Obesity and Other Chronic Diseases.				X
2. Disseminate the Healthy Families Newsletter.			X	
3. Promote and support breastfeeding.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
State WIC staff participated in the development and review of the 2006-2010 Montana Nutrition and Physical Activity (NAPA) State Plan to prevent Obesity and Other Chronic Diseases, particularly with Goal 4: Increase Breastfeeding of Montana Infants. An off-shoot of this goal is the establishment of a Statewide Breastfeeding Coalition to provide a cohesive group for breastfeeding promotion and support within Montana.

At the Spring Public Health Conference a session on the emerging role of breastfeeding in the prevention of obesity and diabetes was presented.

The Eat Right Montana Coalition Healthy Families Newsletter is provided to all local programs. This year's theme is Eat Local, Play Local, Live Healthy. Information contained in the monthly newsletter can be used for news releases or nutrition education for participants.

c. Plan for the Coming Year

Participate in appropriate activities of the Cardiovascular Disease/Obesity Prevention Task Force.

Participate in the Statewide Breastfeeding Coalition. NAPA's goal of increasing breastfeeding as a method of obesity prevention includes establishing a Statewide Breastfeeding Coalition. Montana does not have a cohesive effort to support and promote breastfeeding. The Coalition is in the forming stage, determining mission, goals and objectives. Currently, the Coalition appears to have an agenda that is appropriate for WIC and many of its future activities will target the same population. As the coalition proceeds in its formation, redetermination of the appropriateness of WIC's participation will be made based on proposed activities, target population and resources.

Participate in the Eat Right Montana Coalition.
The selection, review and dissemination of the Healthy Families packets of nutrition and physical activity information and press release is determined by the members. The topics of the last year focused on obesity prevention, including nutrition and physical activity. The topics for the next year will be selected by the members during the September meeting. The materials are provided to all local WIC programs. Other activities will be determined by the members. Other members represent a diverse group of interested parties and allows for networking and forming contacts for the WIC Program. Unless the direction of the Coalition changes or the activities significantly miss the WIC target population, participation will be on-going.

Evaluate the assessment methods and material used with participants for certification and nutrition education.
This will be included in the Value Enhanced Nutrition Assessment Self-Assessment for Montana due December 15, 2006. The Value Enhanced Nutrition Assessment (VENA) implementation plan, based in part on the result of the self-assessment, will be completed by August 15, 2007. A portion of this will include nutrition education related to obesity prevention for participants with appropriate risk factor.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					15.9
Numerator					1668
Denominator					10509
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	15	15	14	14	13

Notes - 2005
The numerator and denominator came from the 2002 PRAMS data collected from mothers in a Point In Time (PIT) state sample. This is all the data we have on mothers during the last three months of pregnancy. Vital stats data does not contain cigarette smoking by trimester of pregnancy.

a. Last Year's Accomplishments
This performance measure is new as of this block grant application. In the past, Montana has reported on the percent of pregnant women who abstain from smoking during pregnancy, using vital statistics data (see State Performance Measure 6). The state does not have a reliable, ongoing source of information on smoking specifically in the last three months of pregnancy. A point-in-time Pregnancy Risk Assessment Monitoring Survey (PRAMS) was conducted in 2002

and the data were analyzed in 2004-2005. The survey results show that 15.9 percent of PRAMS participants smoked in the last three months of pregnancy. This is expected to be an underreporting of the actual frequency of smoking.

In 2005, Montana's Family and Community Health Bureau conducted and participated in the following activities to address smoking cessation:
Reissued contracts to local health departments and tribes to continue to work toward the Public Health Home Visiting (PHHV) objectives including smoking cessation.

Provided training opportunities for PHHV sites focused on tobacco use in pregnancy.

Collaborated with Montana Tobacco Use Prevention Project to increase referral of pregnant women to the quit line.

Participated in the Florida AHEC Network teleconference on Helping Pregnant Women Quit Smoking and distributed teleconference information and materials to PHHV sites.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Public Health Home Visiting (PHHV)/Perinatal Nurse consultant will serve as a consultant to statewide advisory councils on smoking cessation.			X	
2. PHHV/Perinatal Nurse consultant will act as a consultant for the PHHV and Fetal Alcohol Spectrum Disorder (FASD) prevention home visiting projects which promote smoking cessation during and after pregnancy.				X
3. Continue to fund 18 PHHV sites and 5 FASD sites to promote smoking cessation during pregnancy.				X
4. Collaborate with Montana Tobacco Use Prevention Project to promote awareness of smoking cessation and cessation activities for the pregnant woman.			X	
5. Coordinate with tribal health directors and Billings Area Office Indian Health Service staff to coordinate smoking cessation efforts among pregnant and parenting women.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Child and Adolescent Health Section is collaborating with the Montana Tobacco Use Prevention Project to target education on tobacco cessation to pregnant and parenting women.

Education on the smoking cessation quit line and how home visitors can make referrals to the quit line is provided to PHHV sites.

Education on the importance of smoking cessation during pregnancy is provided to support specialists in the Fetal Alcohol Spectrum Disorder (FASD) prevention projects through the regularly scheduled trainings.

Sixteen counties and two reservations have contracts with the Montana Department of Public

Health and Human Services to provide PHHV services which include information and encouragement regarding smoking cessation.

The Child and Adolescent Health Section is collaborating with the March of Dimes on the Prevent Prematurity campaign to educate women on smoking and prematurity and the dangers of second-hand smoke. Information is disseminated through the PHHV and FASD prevention sites.

Information on women and smoking cessation is provided at Fetal, Infant and Child Mortality Review (FICMR) coordinators' meetings and the statewide FIMCR team meeting.

An addiction counselor provided information to FASD support specialists on addiction and smoking cessation at training on June 27, 2006.

c. Plan for the Coming Year

Continue quarterly FASD Advisory Council meetings and FASD support specialist conference calls monthly to promote and provide education on smoking cessation during pregnancy, specifically before third trimester.

Continue to provide funding through contractual agreements with counties and tribes to provide PHHV and FASD Prevention activities and promote smoking cessation throughout pregnancy.

Work with WIC and Family Planning to promote smoking cessation throughout pregnancy across systems.

Continue regularly scheduled meeting with Montana Tobacco Use Prevention Project on a bimonthly basis to promote smoking cessation throughout pregnancy.

Promote March of Dimes Prevent Prematurity Campaign and include tobacco cessation during pregnancy

Educate FICMR coordinators and state team on smoking cessation activities and importance of quitting during pregnancy at one of the two meetings annually.

Provide smoking cessation during pregnancy information to the FCHB Advisory Council.

Attend American College of Obstetricians and Gynecologists (ACOG) and Montana Perinatal Association (MPA) annual meetings to distribute information and provide education on assisting women with smoking cessation during pregnancy to health care providers.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	11.8	11	10.2	9.5	10
Annual Indicator	12.6	14.0	16.9	16.7	25.1
Numerator	9	10	12	12	18
Denominator	71310	71310	71149	71834	71834
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	10	10	9	9	9

Notes - 2005
Denominator data was derived from 2004 Census estimates for Montana children ages 15 to 19 years of age. Numerator data was derived from Vital stats in 2006.

Despite the disparity between objective and indicator, Montana is retaining this objective. Two youth suicide projects, funded in part by federal grants, began in late 2005/2006.

Notes - 2004
Denominator data was derived from 2004 Census estimates for Montana children ages 15 to 19 years of age. Numerator data was updated from Vital stats in 2006.

Notes - 2003
Death information is NOT AVAILABLE from our Office of Vital Statistics at this time. A data system upgrade data conversion process resulted in loss of death statistics for 2003. These data will be updated in next year's MCHBG Report submission.

a. Last Year's Accomplishments
The Child, Adolescent and Community Health (CACH) Section of the Montana Department of Public Health and Human Services (DPHHS) received $50,000 in Preventive Health Block Grant carry-over funds. Five new or continuing sites in local communities will be awarded mini grants for youth suicide prevention projects.

The Montana Strategic Suicide Prevention Plan was updated with youth-specific language.

DPHHS applied for one of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Garrett Lee Smith Memorial grants for youth and young adult suicide prevention. Montana was awarded one of SAMHSA's grants and will fund at least six and up to fifteen community projects to deliver evidence-based practices for youth and young adult (ages 10-24) suicide prevention.

In October of 2005, DPHHS was designated as the lead agency for youth suicide prevention and intervention in Montana. CACH will coordinate suicide prevention efforts.

The Adolescent and School Health Consultant (part of CACH) became a member of the state's Fetal, Infant and Child Mortality Review (FICMR) team.

CACH wrote and disseminated a report on the findings of four community suicide prevention grants funded by Governor Martz in 2004, and the associated community needs assessments.

CACH provided funding through the Governor's Initiative on Youth Suicide Prevention for trainings to communities in a suicide prevention practice known as Question, Persuade, and Refer (QPR), to teach individuals how to ask youth about suicidal thoughts and behaviors and persuade those individuals to seek professional help.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Youth Suicide Prevention Coordinator will serve as consultant to the State Fetal, Infant, and Child Mortality Review (FICMR) team on topics related to youth suicide prevention.				X
2. Six to fifteen communities will be funded for evidence-based youth suicide prevention projects.				X
3. Present a media awareness workshop to inform media on best		X		

practices for suicide reporting.				
4. Advocate with CHIP and Medicaid programs to serve youth with acute care suicidal needs.		X		
5. Work with the state Prevention Resource Center (PRC) and media to promote the idea that suicide is a preventable public health problem.		X		
6. Coordinate tribal and state efforts to reduce youth suicide across the state.				X
7. Collaborate with and support Office of Public Instruction (OPI) efforts to pass a statewide policy on bullying in schools.				X
8.				
9.				
10.				

b. Current Activities
State and local FICMR teams continue to review all youth suicides to identify possible prevention strategies.

Progress of five new mini-grants to communities for youth suicide prevention activities will be reviewed by CACH and technical assistance will be provided to communities as needed.

Montana's Youth and Young Adult Suicide Prevention Task Force will meet quarterly to continue ongoing work on the statewide suicide prevention plan. This task force will form subcommittees to review best practices for suicide prevention and disseminate the recommendations to professionals throughout the state.

CACH is currently developing a Request for Proposals (RFP), which will be used to fund at least six and up to fifteen communities for youth and young adult suicide prevention projects. The funding for this is the Garrett Lee Smith Memorial grant Montana was awarded from SAMSHA.

CACH continues to support QPR training and identify and encourage other best practice methods to prevent both fatal and non-fatal suicidal behaviors among youth aged 10-24. The section also works with the CHIP and Medicaid programs, and develops private partnerships to improve access to and availability of appropriate prevention services for vulnerable youth.

CACH staff members will publish two articles and at least one press release to increase awareness that youth suicide is a preventable public health problem.

The state Adolescent and School Health Consultant promotes and increases access to and linkages with the state's Mental Health and Substance Abuse Services by attending Systems of Care Committee (SOCC) and Connecting for Kids meetings. The consultant also promotes youth suicide prevention across systems through collaborations with the Joint Committee for Healthy Kids (JCHK), SOCC, Juvenile Justice, Children's Special Health Services (CSHS), and Connecting for Kids.

c. Plan for the Coming Year
CACH plans the following suicide prevention activities for 2007:

Continue attendance at SOCC and Connecting for Kids committees to promote and increase access to and linkages with Mental Health and Substance Abuse Services.

Work with schools and multiple systems through the Joint Committee for Healthy Kids (JCHK), Mental Health Systems of Care Committee (SOC), Juvenile Justice, and Children with Special

Health Care Needs (CSHCN), and Connecting for Kids to promote youth suicide prevention across the systems.

Fund at least six and up to fifteen community projects for the implementation of evidence-based practices for the prevention of suicide among Montana's youth and young adults (ages 10-24).

Conduct quarterly meetings of the Suicide Prevention Task Force.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	85	86	86.5	90	90
Annual Indicator	88.8	75.8	88.7	78.7	77.2
Numerator	111	91	102	100	88
Denominator	125	120	115	127	114
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	91	91	92	92	93

Notes - 2004
Trend analysis from 2000 to 2004 indicated an actual decrease in the percent of very low birth weight deliveries, with a 2010 projection of 75.12%. Projections were reset to accommodate for that downward trend in deliveries.

a. Last Year's Accomplishments
"Kicks Count" education was provided to public health nurses, including public heath home visitors.

29 community level teams, who are collectively reviewing deaths for 52 counties and seven reservations, completed Fetal, Infant and Child Mortality (FICMR) reviews. These teams assessed prematurity issues leading to the death of an infant, and initiated changes or made recommendations as appropriate.

In collaboration with the public health data system (PHDS), convened a work group to get input on changes in the PHDS to improve tracking and monitoring maternal risk factors and outcomes.

Accomplished standardization of Public Health Home Visiting (PHHV) Program and provided training to all Public Health Home Visitors.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Serve as statewide consultant to the PHHV and FASD Prevention projects related to prematurity prevention.				X
2. PHHV Nurse Consultant will act as coordinator for the FASD and PHHV Projects, arranging site visits and training as needed.			X	
3. Fund 18 PHHV Projects and 5 FASD Prevention Projects.		X		
4. Make most current FICMR data report available to			X	

stakeholders and Legislators.				
5. Advocate with Medicaid program to continue the provision of Targeted Case Management (TCM) services to at risk pregnant women.				X
6. Coordinate State and Tribal efforts to prevent prematurity.				X
7.				
8.				
9.				
10.				

b. Current Activities
Provide two training opportunities to Public Health Home Visitors on assessment tools and interventions.

Continue to revise and implement changes to data reporting tools to further enhance data collection and retrieval.

Continue to fund Public Health Home Visiting (PHHV) programs.

Plan visits to PHHV sites to assist PHHV programs in providing services and to assess for problem areas in the project.

Continue to provide ongoing support to the community level FICMR coordinators through distribution lists and coordination of two (2) local FICMR coordinator meetings this year.

Provide prematurity prevention materials from the March of Dimes to the FICMR coordinators and public and private providers.

2003 and 2004 FICMR data being analyzed by contracted MCH epidemiologist.
Developing third statewide report of fetal, infant and child deaths with assessment of preventable deaths and community level interventions.

c. Plan for the Coming Year
Collaborate with OB/GYN providers and perinatologists in the state through participation on state level work groups and advisory teams by June 30, 2007.

Continue to fund 18 PHHV Projects and 5 FASD Prevention sites.

Offer prematurity prevention materials to FASD Advisory Council members and PHHV and FASD staff.

Participate in Montana Perinatal Association (MPA) meetings, including planning for this year's conference.

Make most current FICMR report (2003-2004 data) available to legislators and stakeholders around the state.

Provide at least two educational offerings on prematurity prevention to PHHV and FASD project staff.

Collaborate with March of Dimes to promote prematurity prevention statewide.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	84	84.5	85	85.5	86
Annual Indicator	82.5	83.3	84.1	82.6	83.5
Numerator	8922	9067	9571	9513	9528
Denominator	10814	10886	11384	11514	11414
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	85.4	85.9	86.4	86.9	87.4

Notes - 2004
Trend analysis was completed for this measurement.

a. Last Year's Accomplishments
Supported March of Dimes "Walk America" Prematurity Prevention campaign by posting educational materials in the workplace and supporting participation by DPHHS employees.

Attended Spring Public Health Conference April 18-20, 2006 in Billings, Montana focusing on the culture of poverty.

Provided Nurse Child Assessment SatelliteTraining (NCAST), Maternal Mental Health training for 25 public health home visitors.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to support legislative efforts to improve Medicaid reimbursement rates for Medicaid providers.				X
2. Pursue legislation for continued support for FASD prevention.				X
3. The PHHV/Perinatal Substance Abuse Consultant will work with MPA, ACOF, HMHB, MOD and FICMR team to research strategies for increasing early access to prenatal care.			X	
4. Promote social marketing techniques to educate opinion leaders and the public about the importance of early prenatal care.			X	
5. Continued collection of PHHV data relating to entry into prenatal care.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Continue to support Public Health Home Visiting (PHHV) through contractual agreements with local health departments to continue Public Health Home visiting programs. Provide two educational opportunities: Life Skills Progression (LSP) model and Maternal Depression for PHHV staff.

Continued participation in the Early Childhood Comprehensive Services (ECCS) core group meetings and implementation of the ECCS strategic plan which includes development of partnerships and collaborative administration focusing on early childhood and family support.

Required Public Health Home Visiting professionals to establish and maintain a mechanism for identifying high-risk pregnant women.

Continued to fund six PHHV sites for provision of Intensive Case Management (ICM) services to those pregnant women with identified risk factors for abusing substances during pregnancy.

c. Plan for the Coming Year

Coordinate with Medicaid for continued support of Targeted Case Management (TCM) billing and continuation of presumptive eligibility.

Continue to support the PHHV projects through financial and educational support to provide case management services to at risk pregnant women.

Provide at least two educational opportunities to PHHV staff focusing on the needs of at risk pregnant women.

Continue funding the six Fetal Alcohol Spectrum Disorder (FASD) prevention sites.

Continued collaboration with ECCS staff for continued focus on family support and early childhood support family.

Provide support and promote early entry into prenatal care through collaborative efforts with the Family and Community Health Advisory Council, FASD Advisory Council, State FICMR Team, Montana Perinatal Association, Montana Chapter of March of Dimes, Montana Chapter of American College of Obstetricians and Gynecologists (ACOG) and Healthy Mothers Healthy Babies.

D. State Performance Measures

State Performance Measure 1: *Percent of unintended pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	50%	52	54	52	63
Annual Indicator	59.3	64.8	66.1	64.6	64.0
Numerator	1159	1261	1189	1200	1251
Denominator	1953	1946	1799	1858	1955
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	62	62	61	61	60

Notes - 2005

The denominator is total Title X clinic clients. The numerator is the total of these clients with unintended pregnancies.

Notes - 2004
The denominator is total Title X clinic clients. The numerator is the total of these clients with unintended pregnancies. 2009 Revised trend would be 60.6. We recognize challenges with decreasing this unintended rate, which is impacted by factors other than health care access.

Notes - 2003
The denominator is total Title X clinic clients. The numerator is the total of these clients with unintended pregnancies.

a. Last Year's Accomplishments
Unintended pregnancy prevention remains one of sixteen priorities in the Montana Health Agenda, a road map for health service and program action, particularly for the Montana Department of Public Health and Human Service's (DPHHS) Public Health and Safety Division. This priority section outlines the Department's goal to decrease unintended pregnancy and lists specific objectives relating to unintended pregnancy.

The Women's and Men's Health Section (WMHS) maintained contracts with local family planning clinics to assure access to comprehensive reproductive health care for men and women of reproductive age. Additional special initiative funds provided local clinics with funding for local Male Adolescent Clinics; Information, Education and Communication (IEC) projects; Client, Family and Community Involvement (CFC); Strategic Referrals and for Contraceptives and Technology to provide efficacious contraceptives to low-income clients.

The service expansion and other special initiative projects have lead to an increase in the number of unduplicated clients served by local clinics. In SFY 2005, the number of clients served increased to 29,055. It is estimated that Title X family planning services prevented approximately 20,404 unintended pregnancies, including 2,891 abortions, during SFY 2005.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. In State Fiscal Year (SFY) 2007, provide FP services to at least 29,500 clients at risk of unintended pregnancy.	X			
2. In SFY 2007, ensure that 97% of female FP clients using contraception do not experience an unintended pregnancy.	X			
3. In SFY 2007, at least 69% of family planning clinic clients will be at or below 150% of federal poverty level.	X			
4. In SFY 2007 provide funding to 15 agencies with services in 29 clinics for efficacious contraceptives for low-income clients (below 250% of poverty).				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The WMHS contracts with agencies statewide to provide family planning and reproductive health care to women at risk of unintended pregnancy. Data on contraceptive use and effectiveness is monitored and evaluated. Outreach and education are provided to low-income clients (defined as 150% or less of FPL). The WMHS also provides special funds for high-cost and efficacious contraceptives for low-income women.

The WMHS provides outreach materials to county Offices of Public Assistance; community action programs; Healthy Mothers, Healthy Babies; Public Health Home Visiting Programs; WIC offices; local Breast and Cervical Health Program sites; and Indian Health Services. Family planning programs also receive outreach materials and distribute them to clients and community partners. Outreach materials include the 24-hour toll-free hotline number to assist clients in finding the nearest Family Planning Clinic.

The WMHS provides fact sheets on the topics "What is Family Planning?," "The Benefits of Family Planning Activities," and "Accomplishments of the State Family Planning Program." These fact sheets are used in conjunction with the family planning display and are distributed to local Title X clinics and used to educate legislators on family planning issues.

Legislation passed in 2003 allows the Department to pursue a 1115 Medicaid Waiver to expand family planning services to low income women in Montana. The draft waiver is currently being reviewed by the Department and will become available for public comment in the summer of 2006. It is anticipated that the waiver will be submitted to the Centers for Medicaid and Medicare Services in late 2006.

A referral system has been developed to allow rural agencies without the capacity to provide IUD insertions to refer these clients to larger agencies. This system increases the availability of IUDs for low-income women. The IUDs are provided through the federal regional efficacious contraceptive funds.

During SFY 2006, the WMHS received special grant funding for local Male Adolescent Clinics, Information, Education and Communication (IEC) projects, Client, Family and Community Involvement (CFC), Strategic Referrals, and Contraceptives and Technology. Local male clinics use teen male interns to increase the number of male clients reached. The IEC projects fund local clinics to increase family planning services awareness and knowledge of reproductive health. The CFC projects focus on outreach to special needs populations, parents and school districts to increase awareness and support for family planning services. The Strategic Referrals project will improve community collaboration and partnerships to enhance service delivery. Through Contraceptives and Technology special funds, WMHS can support highly effective contraceptives, including emergency contraceptives, thereby reducing teen pregnancy rates as well as the teen birth rate and unintended pregnancy.

c. Plan for the Coming Year

During the coming year, the WMHS plans to address unintended pregnancy through continued contracts with its local family planning clinics providing comprehensive reproductive health care in 29 locations to residents of all 56 Montana counties. Because low-income clients are at increased risk of unintended pregnancy, the WMHS will continue to offer comprehensive family planning services targeting low-income men and women.

Through training and educational activities, the WMHS plans to assist local family planning programs in providing quality medical, clinical counseling and education services for all clients. A training needs assessment is distributed annually to local family planning clinics to develop educational goals and training programs. Such training improves the service and quality of care in reducing unintended pregnancies among clients of local family planning programs.

The WMHS will provide health education materials on unintended pregnancy to local programs and other public health partners. These materials will be updated to reflect the increased availability of information in an electronic format. The health educator will continue to investigate on-line resources and other sources of current information that includes unintended pregnancy prevention.

The WMHS has applied for strategic initiative funding in SFY 2007 that supports targeted projects to expand services to an underserved community (Big Sky, MT), improve community teen pregnancy prevention partnerships (Bozeman, MT), and improve and expand access to family planning services within urban Indian populations (Billings, Butte, Great Falls, Helena, Missoula). All three of the strategic initiative proposals address the HP 2010 goal to reduce the rate of unintended pregnancy and two of the proposals directly target reducing pregnancies among adolescent females.

The WMHS will continue to provide special funding for efficacious contraceptives to local family planning clinics. These high-cost and highly effective contraceptives will be provided to low-income clients who fall at least below 250% of the federal poverty level.

State Performance Measure 2: *Percent of women who abstain from alcohol use in pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	98%	98	98	98	98
Annual Indicator	98.3	96.9	97.2	97.0	97.0
Numerator	10668	10552	10959	11203	11122
Denominator	10857	10886	11276	11554	11468
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	98.3	98.5	98.6	98.7	98.9

Notes - 2005
The numerator for 2004 and 2005 was generated from vital records by including the number of women delivering live births and not drinking alcohol plus the number of women experiencing fetal deaths and not drinking alcohol. Denominator data was all women either experiencing a live birth or a fetal death for the years in question. Vital records data on alcohol use in pregnancy is based on self-report and therefore is probably an underestimation of the actual incidence.

a. Last Year's Accomplishments
Provided training for 35 public health home visitors on the American College of Obstetricians and Gynecologists (ACOG)'s domestic violence screening tool; the 4Ps tool for alcohol, drug, and tobacco screening; the Life Skills Progression assessment; targeted case management; and data collection.

Facilitated reflective supervision conference calls with public health home visitors to improve intervention skills.

Conducted a needs assessment to determine needs and best interventions for women at risk of alcohol use in pregnancy including four focus groups of at risk public health consumers.

Attended Fetal Alcohol Spectrum Disorder (FASD) State Systems Building Conference and presented poster session and moderated two breakout sessions.

Submitted FASD Request For Proposal to Northrop Grumman for FASD subcontract for prevention, identification, and treatment of FASD.

Facilitated three Fetal Alcohol Syndrome (FAS) Advisory Council meetings from January to May.

Submitted four deliverable reports the Kick Off Meeting; Work Plan and Timeline for Task Force and Needs Assessment; Needs Assessment Findings; and Proposed Strategy Report to comply with FASD subcontract and to plan for the coming year's intervention.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to support legislative efforts to prevent FASD through funding to support the FASD prevention projects.				X
2. The PHHV/Perinatal Nurse Consultant will work with the PHHV sites, FASD sites, FCHB Advisory Council, Montana Perinatal Association, March of Dimes, ACOG and the FASD Advisory Council to continue statewide efforts to reduce FASD.			X	
3. Continued collection of PHHV and FASD site data relating to FASD prevention.				X
4. Continue to fund FASD prevention sites through funding from SAMHSA.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continue to fund six Public Health Home Visiting (PHHV) sites to provide intensive case management to women with risk factors that may make them more likely to drink and use substances during pregnancy. A support specialist works with the professional home visiting team to provide home visiting on a weekly basis.

Continue to work with the FASD contractor, Northrop Grumman to receive technical assistance as needed for the FASD prevention project.

Continue to provide the support specialists and PHHV professional staff with education on FASD prevention.

Conduct quarterly meeting of the FASD Advisory Council to provide information on prenatal substance abuse and inform council members of the status of the project.
Monthly conference calls with the support specialists to assure successful FASD intervention through networking and problem solving.

Continue to provide information to the Department of Public Health and Human Services (DPHHS) Director and Public Health and Safety Division (PHSD) Administer of the importance of the FASD Project related to the Executive Planning Process (EPP).

The June 26-28 training of support specialists focused on the FASD curriculum and activities to implement on home visits with the high risk pregnant women on their case load.

Staff and invited stakeholders from Montana attended the Substance Abuse and Mental Health Services Administration (SAMHSA) Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence "Building FASD State Systems" (BFSS) meeting in San Francisco, California, on May 9 through 11, 2006.

Continue to facilitate and enhance development of systems of care in Montana communities by providing technical assistance to public and private providers through advisory councils and work groups.

A work group has been established with the Addictive and Mental Disorders Division (AMDD) to discuss home visiting and services to reduce substance abuse during pregnancy.

c. Plan for the Coming Year
Coordinate with AMDD to support efforts to prevent duplication of services and enhance services for substance abusing women.

Continue to fund FASD prevention projects to provide intensive case management by support specialists and to collect data on FASD prevention.

Provide training to support specialists in November 2006.

Nurse Consultant will conduct monthly teleconferences with support specialists.

Continue FASD Advisory Council meetings on a quarterly basis.

Present results-to-date information on the Support Specialist model at the spring public health conference.

State Performance Measure 4: *Percent of state fetal/infant/child deaths reviewed for preventability by local review teams.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	90%	95	95	95	95
Annual Indicator	76.8	91.1	88.0	92.8	63.5
Numerator	43	184	183	155	120
Denominator	56	202	208	167	189
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	95	95	95	95	95

Notes - 2005
Data are still being collected from review teams. Fetal, Infant and Child Mortality Review teams may review deaths as long as 6-12 months after the event.

Notes - 2004
Provisional data until next report year.

Notes - 2003
FICMR reviews are always performed retrospectively, and in most case 6-12 months after the deaths. 2002 data was recently finalized, with a noted change in the data as reported last year—Corrections are: Annual indicator-91%, Numerator-184, Denominator-202. 2003 data will not be completed until January 2005. Annual performance objective of 95% may not be attainable because some child deaths are transfers from out of state facilities.

a. Last Year's Accomplishments

Successfully sustained the Fetal, Infant and Child Mortality Review (FICMR) program with Maternal and Child Health Block Grant (MCHBG) funding.

Distributed second "mock case review" to each local team for determination of inter-panel reliability with a 79% return rate of mock case.

2001-2002 FICMR data analyzed by MCH epidemiologist, and report published and distributed statewide.

Provided child abuse and neglect education and prematurity prevention education and "kits" to FICMR coordinators.

Provided youth suicide prevention grant funding to three FICMR teams.

Implemented a Sudden Infant Death Syndrome (SIDS) outreach campaign to all alternative schools.

Implemented a Safe Sleep for Baby project, providing cribs and education.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to support legislation to prevent fetal, infant and child deaths in communities in Montana.				X
2. Distribute FICMR report on 2003-2004 data to stakeholders and legislators.			X	
3. Promote current SUID reporting on form and scene investigation through coordination with the training staff for law enforcement officers and coroners.			X	
4. Promote social marketing techniques to educate policy makers and the public about preventable deaths of children and infants in Montana.			X	
5. Continued support of local FICMR teams on collection of FICMR data related to preventable deaths.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Child, Adolescent and Community Health (CACH) Section has regularly scheduled meetings with the WIC staff to promote educational materials on Safe Sleep for breastfeeding Moms. Informational brochure has been developed and will be made available to moms at the WIC clinics.

2003-2004 FICMR data is being analyzed by a MCH epidemiologist who is collaborating with a MD to write a report of these data. The final report is expected to be available in early 2007. The information will be shared with legislators and state and local stakeholders and is intended to help identify prevention or intervention activities in order to decrease the number of fetal, infant, and child deaths.

Local communities continue to conduct FICMR reviews and send data on FICMR to DPHHS on a

quarterly basis.

The Child Health Nurse Consultant convenes state FICMR team meetings and FICMR coordinator meetings twice a year. The next meetings are scheduled for September of 2006.

The FICMR data collection tool has been revised and support staff at DPHHS is entering information into a revised ACCESS data base.

CACH is collaborating with the state medical examiner and state FICMR team members to get information on the Sudden, Unexplained Infant Death (SUID) reporting form and scene investigations on the training format of law enforcement officers and coroners for this upcoming fall.

c. Plan for the Coming Year

Continue to work with the Daycare Licensing Section to develop Administrative Rule mandating "Back to Sleep" for babies in daycare through regularly scheduled meetings.

Newly hired Public Health Home Visiting (PHHV)/Perinatal Nurse Consultant will participate on the Drug Endangered Child task force.

Continue collaborative effort with WIC section on Safe Sleep for breastfeeding mothers through bimonthly meetings of WIC staff and Child Health Nurse Consultant.

Continue to provide information on the "Safe Haven" law to health departments, advisory councils, day cares, and other public-private providers in the state by the Child Health Nurse Consultant.

Continue to educate FICMR coordinators, coroners and law enforcement officers about the new CDC SUID reporting form and investigations by arranging for the information to be on the agendas of coroner and law enforcement training. Continue to work with the state medical examiner to promote use of the new form.

Provide education at the FICMR coordinators meeting in Sept. 06 about "Period of Purple Crying" for prevention of child abuse and neglect.

Continue to collaborate with Healthy Mothers Healthy Babies (HMHB) on the Safe Sleep Project by providing technical assistance (TA) and guidance during the transfer of the project to them. Child Health Nurse Consultant acts as the coordinator and TA for this project.

Sustain FICMR program at the current level through MCHBG funding and education and support from the child health nurse consultant.

Form a subcommittee of the state FICMR team to evaluate membership and governance of State FICMR team, and make changes as needed.

Provide bereavement information to county FICMR coordinators at the Sept. 2006 coordinators meeting.

Analyze FICMR data for 2003 and 2004 and publish third statewide report. Make the report available to stakeholders and legislators. The FICMR reports are released every two years to coincide with Montana's legislative sessions. Aggregating two years of data also provides a better overview of the major causes of fetal, infant and child deaths and possible prevention strategies.

State Performance Measure 5: *Percent of Medicaid eligible children who receive dental services as part of their comprehensive services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	30	31	32	33	23
Annual Indicator	23.0	23.7	23.4	22.6	23.3
Numerator	12327	14123	14649	14707	15374
Denominator	53594	59578	62629	65079	66078
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	20.4	19.5	18.6	17.8	17

Notes - 2005
This data came from the Early Periodic Screening Diagnostic Treatment (EPSDT) report from the Montana Medicaid Program. It is an annual report for FY 2005.

Notes - 2004
This data came from the Early Periodic Screening Diagnostic Treatment (EPSDT) report from the Montana Medicaid Program. It is an annual report for FY 2004 and was updated in 2006 with final data.

a. Last Year's Accomplishments
To ease the administrative burden for providers, the Covered Services Section of the Medicaid Dental Provider Manual was updated and many provider suggestions including, dental fee schedule code reimbursement, all Medicaid covered Current Dental Terminology (CDT) codes, CDT code allowed minimum and maximum age, and all service limitations per Code were incorporated in one convenient place.

Montana Dental Advisory Board meetings were held to discuss provider's requests to close existing codes and open new ones. The Board adapted their requests.

Dental provider informational bulletins were included in the Medicaid Provider Claim Jumper monthly newsletter.

Personal meetings were held with individual and area provider groups regarding Medicaid concerns and program ideas.

The Basic Dental Emergency Form was updated to include the current codes and the fee schedule to include the minimum and maximum ages on the covered codes.

The DPHHS Oral Health Consultant attended the National Oral Health Conference and gained a wealth of knowledge on the latest oral health information.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Montana continues to explore several new ideas to address dental access; including the “Rent A Practice” for a day.		X		
2. Medicaid attendance at the 2006 National Oral Health Conference to gain knowledge and participate in networking				X

opportunities.				
3. Ongoing participation as a member of the Montana Oral Health Coalition.				X
4. Continue ongoing collaboration with Montana Dental Association and the Oral Health Consultant.				X
5. Pursue avenues to increase participation of dental providers in Medicaid.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Covered Services Section of the Medicaid Dental Provider Manual continues to be updated by incorporating the provider's suggestions in one convenient place.

The Basic Dental Emergency Form continues to be modified with current CDT codes.

The fee schedule was updated to include the new July 1, 2005 CDT 5 codes and the increased reimbursement rates.

Ongoing membership on the Montana Oral Health Coalition that included participation in implementing the State Oral Health Plan as it relates to Medicaid.

Coordinated with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Physician Guidance Workgroup to implement a fluoride varnish training protocol that included billing for the procedure, to incorporate a new EPSDT manual into the physician manual, and to develop a website link for convenience.

Coordinated the training for Passport to Health medical providers to conduct oral health screenings as part EPSDT well-child exams. This will also include dissemination of Bright Futures in Practice: Oral Health Guide for anticipatory guidance along with facts about Early Childhood Caries and the importance of good oral health for women to reduce adverse birth outcomes.

The 2005 Legislative session provided DPHHS with tobacco funds for the Medicaid Dental Program. These funds were used for increasing dental fees as of July 1, 2005 and for exploring projects, such as "Rent A Practice For A Day"aimed at increasing dental care in low access areas. In addition to their regular fee-for-service reimbursement, providers participating in the "Rent A Practice For A Day" would be paid a lump sum for new Medicaid clients.

c. Plan for the Coming Year
Montana will continue to explore innovative solutions addressing the access issue, including further study of the "Rent A Practice For A Day" and methods to increase participation of dental providers.

Montana plans to maintain its collaborations with Montana Dental Association, the Oral Health Consultant, Community Health Centers and providers to promote prevention programs aimed at children and pregnant mothers.

Montana plans to attend the 2006 National Oral Health Conference to gain knowledge and

participate in networking opportunities.

State Performance Measure 6: *Percent of pregnant women who abstain from cigarette smoking.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	81%	81	81	82	83
Annual Indicator	81.8	80.3	80.5	80.6	81.0
Numerator	8849	8746	9204	9308	9284
Denominator	10814	10886	11439	11554	11468
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	81.6	81.6	81.7	81.7	81.8

Notes - 2005
Numerator data for 2003, 2004, and 2005 was generated by Vital stats and includes both women who delivered a live birth and who experienced a fetal death and did not smoke during pregnancy. Denominator data included women experiencing a live birth or fetal death.

a. Last Year's Accomplishments
Reissued contracts to local health departments and tribes to continue to work toward the Public Health Home Visiting (PHHV) objectives including smoking cessation.

Provided training opportunities for PHHV sites focused on tobacco use in pregnancy.

Collaborated with Montana Tobacco Use Prevention Project to increase referral of pregnant women to the MT Quit Line.

Participated in the Florida Area Health Education Center Network teleconference on Helping Pregnant Women Quit Smoking and distributed teleconference information and materials to PHHV sites.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. PHHV/Perinatal Nurse consultant will serve as a consultant to statewide advisory councils on smoking cessation.			X	
2. PHHV/Perinatal Nurse consultant will act as a consultant for the PHHV and FASD prevention home visiting projects which promote smoking cessation.				X
3. Continue to fund 18 PHHV sites and 5 FASD sites to promote smoking cessation.				X
4. Collaborate with MTUPP to promote awareness of smoking cessation and cessation activities.			X	
5. Coordinate with tribal health directors and BAO IHS staff to coordinate smoking cessation efforts among pregnant and parenting women.				X
6.				
7.				
8.				

9.				
10.				

b. Current Activities
The Child and Adolescent Health Section is collaborating with the Montana Tobacco Use Prevention Project to target education on tobacco cessation to pregnant and parenting women.

Education on the smoking cessation quit line and how home visitors can make referrals to the quit line is provided to PHHV sites.

Education on the importance of smoking cessation during pregnancy is provided to support specialists in the Fetal Alcohol Spectrum Disorder (FASD) prevention projects through the regularly scheduled trainings.

Sixteen counties and two reservations have contracts with the Montana Department of Public Health and Human Services to provide PHHV services which include information and encouragement regarding smoking cessation.

The Child and Adolescent Health Section is collaborating with the March of Dimes on the Prevent Prematurity campaign to educate women on smoking and prematurity and the dangers of second-hand smoke. Information is disseminated through the PHHV and FASD prevention sites.

Information on women and smoking cessation is provided at Fetal, Infant and Child Mortality Review (FICMR) coordinators' meetings and the statewide FIMCR team meeting.

An addiction counselor provided information to FASD support specialists on addiction and smoking cessation at training on June 27, 2006.

c. Plan for the Coming Year
Continue quarterly FASD Advisory Council meetings and FASD support specialist conference calls monthly to promote and provide education on smoking cessation.

Continue to provide funding through contractual agreements with counties and tribes to provide PHHV and FASD Prevention activities and promote smoking cessation in pregnant women.

Work with WIC and Family Planning to promote maternal smoking cessation across systems.

Continue regularly scheduled bimonthly meeting with Montana Tobacco Use Prevention Project to promote smoking cessation among pregnant women.

Promote March of Dimes Prevent Prematurity campaign and include information on tobacco cessation amongst pregnant and post partum women.

Educate FICMR coordinators and state team on smoking cessation activities at one of the two meetings annually.

Provide smoking cessation information to the Family and Community Health Bureau (FCHB) Advisory Council.

Attend American College of Obstetricians and Gynecologists (ACOG) and MPA annual meetings to distribute information and provide education on smoking cessation to health care providers.

State Performance Measure 7: *Rate of firearm deaths among youth aged 5-19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	7.9%	7.7	7.4	7.2	7
Annual Indicator	8.4	7.4	10.0	12.9	11.1
Numerator	17	15	19	24	20
Denominator	202571	202571	189774	185464	180271
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	8	8	8	8	8

Notes - 2005
2005 Data has been updated using Vital Statistics on 5 to 19 year olds (done in 2006). Numerator is the number of deaths for youth ages 5 to 19 who were declared dead due to a firearm. Denominator data is from US Census Bureau projections (released 8/4/2006).

Notes - 2004
Denominator data was derived from 2004 Census estimates for Montana children ages 5 to 19 years of age. Numerator is the number of deaths for youth ages 5 to 19 who were declared dead due to a firearm.

Notes - 2003
2003 Data has been updated using Vital Statistics on 5 to 19 year olds (done in 2006). Numerator is the number of deaths for youth ages 5 to 19 who were declared dead due to a firearm. Denominator generation source is unknown.

a. Last Year's Accomplishments
Governor Schweitzer launched a statewide gun safety initiative, championed proper handling and storage of firearms, and coordinated efforts with Project Child Safe, a nationwide program whose purpose is to promote safe firearms handling and storage practices among all firearms owners.

The State Fetal, Infant and Child Mortality Review (FICMR) coordinator produced a fact sheet and a press release on gun safety and storage based on Behavioral Risk Factor Surveillance Survey (BRFSS) data, for distribution to the public.

The local FICMR teams expanded their capability to review children's deaths by including more counties and reservations in the FICMR reviews. The State and local teams continued to make recommendations for death prevention at the local level. Some local teams distributed gunlocks at local health fairs.

Efforts continued to recruit physicians into educating parents on safe gun use and storage safety in the home.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Produce a press release at the beginning of the hunting season to promote awareness of safe firearm handling.			X	
2. Provide at least two suicide prevention education and awareness workshops to emergency room and first responder professional staff, promoting means restriction relating to firearms.			X	
3. The Youth Suicide Prevention Coordinator will coordinate with the State Fetal, Infant and Child Mortality Review (FICMR) team				X

quarterly meetings to track firearm-related youth homicide and suicide completion rates and consider prevention strategies.				
4. Develop and disseminate a Request for Proposals (RFP) for community-based suicide prevention projects.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Montana's Adolescent Health Coordinator continues to work with the State's FICMR teams to gather and monitor data and to identify possible strategies for promoting gun safety practices.

Gun safety and safe storage awareness are promoted via press releases and collaboration with local FICMR teams to disseminate firearm safety pamphlets to gun merchants in their communities.

The Child, Adolescent and Community Health (CACH) section of the Montana Department of Public Health and Human Services (DPHHS) is continuing support for gun safety and awareness classes for youth provided by Fish Wildlife and Parks, 4-H, local public health departments and schools. Gun safety and safe storage of firearms is also routinely included in education provided during home visits to high-risk pregnant women and high-risk children. Suicide prevention programs at the state and local level are supported by provision of available brochures and other materials.

CACH continues outreach efforts with firearm retailers to provide them with information for consumers about child and gun safety. Collaboration with Healthy Child Care Montana and the Child Care Licensing Bureau to incorporate firearm safety in child care settings is also being explored.

Firearms are the leading means of suicide among the Montana's 15-19 year olds. The state's Youth and Young Adult Suicide Prevention Project is developing a Request for Proposals (RFP) for community-based suicide prevention projects. Applicants are directed to the Suicide Prevention Resource Center's Registry of Evidence-Based Practices as a source of information on prevention programs and interventions. Among the prevention options is the Emergency Department Means Restriction Education program, which targets 16-19 year-old youth assessed as being at risk for suicidal behavior. The program is rated to be "effective" in reducing access to lethal means.

c. Plan for the Coming Year
CACH plans the following firearm-related activities for 2007:

Continue to promote awareness of gun safety practices through press releases to the public accentuating the practice of storing guns unloaded and locked and locking ammunition in a location away from guns.

Coordinate with the State FICMR team and BRFSS coordinator to monitor data on firearm deaths and identify prevention opportunities.

Collaborate with State Injury Prevention Coordinator to inform the public on gun safety via state EMS/Trauma webpage. The webpage includes state statistics, prevention tips for kids, adults,

parents, locations to get free or low-cost trigger locks, and links to downloadable games for teachers.

Continue support for gun safety and awareness classes for youth provided by Fish Wildlife and Parks, 4-H, local public health departments and schools.

Continue to support educational efforts toward gun safety and safe storage of firearms that is provided during home visits to high-risk pregnant women and high-risk children.

Coordinate efforts with the Statewide Youth and Young Adult Suicide Prevention Project to promote awareness of proper and safe storage of firearms through production of brochures and promotion of means restriction trainings.

State Performance Measure 8: *Percent of low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			6.7	7.7	6.6
Numerator			767	881	757
Denominator			11384	11514	11414
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	6	6	6	6	6

Notes - 2005
Birth records for Montana residents born outside of the state are not yet included in this number.

a. Last Year's Accomplishments
Prematurity and low birthweight prevention education was provided to Montana's Fetal, Infant, and Child Mortality Review (FICMR) coordinators, Public Health Home Visiting (PHHV) and Fetal Alcohol Spectrum Disorder (FASD) partners. Specific risk factors, such as methamphetamine use, were also discussed. All of the programs interact with communities or directly with clients and have multiple opportunities to educate women and their families about risk factors and prevention.

Contracts to continue and expand Montana's PHHV and FASD programs were also issued in 2005.

FICMR coordinators received Prematurity Prevention Kits for educational outreach.

The PHHV partners, who work directly with women and their families, received two trainings in 2005; one on maternal mental health, and the other on the Life Skills Progression (LSP) tool. LSP is used by the PHHV sites to help a woman and her family make better choices, including accessing prenatal care earlier and being aware of risk factors for prematurity and low birthweight. March of Dimes Prematurity Prevention materials were also distributed to PHHV and their clients.

Discussions were held with the Indian Health Service Maternal and Child Health (MCH) Consultant on prematurity prevention outreach for the Native American population.

Support for and interest in the March of Dimes "Walk America" Prematurity Prevention Campaign was encouraged by posting educational materials in the Montana Department of Public Health

and Human Services (DPHHS) and supporting participation by DPHHS employees. This served to make employees aware of the risk factors and raise the awareness of low birthweight as an issue related to their own programs.

DPHHS' Child Health Nurse Consultant (CHNC) participates in several cross-cutting committees related to child health and risk factors for low birthweight. In 2005, she participated on the Drug Endangered Children Task Force, which includes discussions around the effects of and opportunities to address prenatal drug exposure, and the Children's Environmental Health Committee, which discussed prenatal exposures to environmental contaminants. The CHNC also facilitated a presentation on Drug Endangered Children at the Spring Public Health Conference (which includes public health providers from across Montana) and participated in the Florida Area Health Education Center (AHEC) Network teleconference on Helping Pregnant Women Quit Smoking.

DPHHS' Child, Adolescent and Community Health (CACH) Section promoted prematurity prevention as a component of Medicaid's Targeted Case Management (TCM) program. TCM provides assessment, monitoring and referral of clients.

FICMR coordinators received cultural competence training from the National Center for Cultural Competence at Georgetown University. Culturally competent approaches to clients will assist the coordinators with outreach and education, and will encourage women and their families to be more receptive to the messages.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue collection and review of Fetal, Infant, and Child Mortality Review (FICMR) and Public Health Home Visiting (PHHV) data related to low birthweight.				X
2. Promote good prenatal care and prevention of preterm birth through PHHV and intensive case management by support specialists in the Fetal Alcohol Spectrum Disorder (FASD) prevention projects.		X		
3. Promote good prenatal care and prevention of low birthweight infants through the work of the FICMR state team and FICMR coordinators.				X
4. The PHHV/Perinatal Substance Abuse Nurse Consultant will continue to provide education and training to the public health home visitors and FASD support specialists on prevention of low birthweight.				X
5. Continue to provide funds to PHHV sites and FASD prevention sites to collect data related to low birthweight.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Discussions with the Indian Health Service MCH Nurse Consultant and contractual arrangements with tribes for PHHV activities and FASD prevention continue to strengthen state and tribal efforts to prevent prematurity and low birth weight.

Methamphetamine use was the topic of the Montana Perinatal Association conference in April 2006, and effects on the fetus and pregnancy were presented. PHHV staff from around the state attended this conference.

Contractual agreements have been established with counties and tribes to continue to provide PHHV services to high-risk pregnant women and at FASD prevention sites.

A new Public Health Home Visiting/Perinatal Substance Abuse Nurse Consultant was hired to coordinate state PHHV and FASD activities. The position had previously been vacant for several months.

A new Child Health Nurse Consultant was hired to coordinate state FICMR activities, school health activities and child health outreach and education. The previous Child Health Nurse Consultant retired in May of 2006.

Prematurity prevention outreach was provided to FICMR coordinators, PHHV sites and FASD Prevention networks to keep them up-to-date on prevention opportunities and approaches.

The most recent March of Dimes Prematurity Prevention materials were distributed to FICMR team members, coordinators and PHHV and FASD sites.

The March of Dimes "Walk America" Prematurity Prevention campaign was supported through staff time and education of partners to assist with raising interest in and support for prematurity prevention.

Training was provided to FASD support specialists on the signs and symptoms of premature labor.

c. Plan for the Coming Year

Continue contractual arrangement with counties and tribes to provide PHHV and FASD prevention services.

Convene quarterly meeting of the FASD Advisory Council, and twice yearly meetings of the FICMR coordinators and statewide FICMR team.

Continue to provide prematurity prevention outreach to FICMR coordinators, PHHV sites and FASD prevention networks.

Continue to utilize and disseminate March of Dimes Prematurity Prevention materials through advisory council meetings.

Provide at least one site visit to each PHHV and FASD contractor by June 30, 2007.

Publish the third FICMR report, which addresses prematurity and low birth weight risk factors by September 30, 2006.

Disseminate the information in the third FICMR report to stakeholders across the state, including legislators during the 2007 legislative session.

Contact and coordinate telephone meetings with perinatologists and neonatologists around the state to coordinate prematurity prevention education.

E. Health Status Indicators

The Health Status Indicators (HSIs) are a useful source of multi-year data on the measures. Montana's relatively small population can result in a low number of cases for some outcomes, particularly for uncommon health events. Alternatively, an increase or decrease of one or two cases from one year to the next can result in the appearance of drastic increases or decreases in the rates of some outcomes. Major increases in the frequency of a particular event from one year to the next do not necessarily demonstrate a significant increase, and while small numbers of events or outcomes present particular opportunities and challenges in analysis, they are not necessarily an indication of a lack of need. Therefore, annual frequencies, rates or calculations may vary widely and be less descriptive than the multi-year perspective captured in the HSIs.

Collecting the health status indicators in one location, at one time is a useful overview on Montana's residents. The data reported in the HSIs are used often in grant applications, reports and programmatic activities, but they are often only on more specific topics. For example, data on motor vehicle crashes and sexually-transmitted diseases are discussed and used within those programs, but rarely are data on such programmatically disparate topics brought together and used to create a broader perspective of the health status of the state's population.

Some health status indicators are more useful than others in serving as surveillance and monitoring tools or acting as evaluative measures. Montana encounters challenges in reporting on some of the health status indicators, specifically those for which something other than vital records is the expected data source. Those health status indicators are less helpful information on the state's residents, although some of them provide a data collection goal to strive for.

For those health status indicators that Montana does not have an ongoing, stable source of data for, such as the rate of nonfatal injuries among children (HSI04A), investigating possible data sources can result in new connections with programs outside of the state Title V program and increased knowledge within the Title V program of activities elsewhere in the health department. While this is useful programmatically, it does often mean that the indicator itself is not comparable from year to year and does not offer an accurate perspective on the health status being measured.

Some information collected in the HSIs may be more useful in directing public health efforts with additional narrative information to provide perspective or background on the measure. For instance, in the 2007 MCH Block Grant Application, Montana has added low birth weight as a new state performance measure. Although birth weight under 2,500 grams is already captured in Health Status Indicator 01A, prevention of low birth weight and premature birth are priorities of the Family and Community Health Bureau (FCHB), and the narrative section of the performance measures allows the state to track the data as well as related initiatives, programs and interventions.

F. Other Program Activities

Although mentioned elsewhere in this document, the importance of continuing to develop and refine the public health system and its capacity to support the delivery of the core functions and essential services of public health is worth emphasizing. Due to the rural/frontier nature of much of the state, we depend upon a public health workforce that is overburdened and under funded. In order to maximize the health of the public, and specifically the health of the MCH population, it is important that state level efforts continue to focus on supporting linkages and encouraging efficient delivery of services. A focus on population-based services is also key, with MCH continuing to struggle with its perceived role as a safety net provider of services otherwise not available or funded. The efforts of the Public Health Improvement Bureau and the public health

informatics section will continue to help educate and support the workforce, and to improve and streamline reporting in order to decrease the burden on local contractors.

REviewer questions asked for an examination of the low birth weight (LBW) incidence in Montana. A review of the existing data revealed that the appears to be a trend in the incidence of LBW births in Montana. Low birth weight, defined as births less than 2500 grams, is a standard indicator of perinatal health at both the state and federal levels. In response to this concern, a low birth weight trend analysis was performed on aggregate state data for the years 1995 to 2004, stratified by year and race. Using the Cochran-Armitage test for trend for the years in question regardless of race, there appeared to be a significant positive linear trend for the occurrence of low birth weight events in the state. Further investigation into the trend revealed though Native American populations were 16% more likely to have a low birth weight baby than Caucasian populations, however, they were not the cause of the positive linear trend, with noticeable highs and lows apparent for multiple years. The Caucasian population's variability over time was the significant cause of the positive linear trend seen in the analysis, rising approximately 30% since 1995.

In addition, strategic planing will be a focus during the remainder of 2005 and 2006. Further prioritization of health needs will occur using the priorities identified by stakeholders throughout the state and the involvement of FCHB Advisory Council Members and staff.

G. Technical Assistance

Technical assistance needs identified to date include:

1. The Child, Adolescent and Community Health (CACH) Section has identified the need for training on the Ages and Stages Questionnaire, which is being used by the Public Health Home Visitors, in their visits with Montana's high-risk pregnancy population. The individuals who use this tool have requested training, but limited state funding precludes our ability to provide it. Liz Trombley from the University of Oregon has been identified as the trainer.

2. The Children's Special Health Services (CSHS) Section has identified the need for assistance in developing and applying tools to measure and monitor the CSHCN-related performance measures. The goal is to develop Montana-specific monitoring tools and an accompanying methodology for applying these tools. No contractor has been identified; recommendations from MCHB and other states would be used to identify possible individuals.

3. The Child, Adolescent and Community Health (CACH) Section has identified the need to coordinate public and private efforts that promote injury prevention in children. Montana's rates of unintentional injury and motor vehicle-related injury in children continue to be high, but there is limited state-level coordination of data collection and prevention efforts. No contractor has been identified.

V. Budget Narrative

A. Expenditures

Montana depends upon its local partners for provision of MCH services to the population. 42% of the MCHBG is distributed to local county contractors under MCH services contract. Local match continues to be well beyond the reuired level, with local match of about $3.6 million, instead of the approximately $825,000 which would be required under the present contract. Montana does not have enough state general fund to pull down the federal funding, with a total of slightly over $1 million, instead of the $1.9 million needed.

Local match continues to increase, partly due to improved reporting expectations and compliance, and due to the response of locals to the request for accurate reporting which will allow better understanding of true costs of MCH services. For the first time in 2004, we were able to capture and report the program income.

Please see attachment for charts depicting trends.

Form 3 - Federal funding stayed about the same from 2001 through 2004 - federal decreases in 2005 and potentially 2006 will result in a drop in the federal level. The state funding also continues to go down slightly. Efforts to increase funding are anticipated for the 2007 session, depending upon fiscal picture. Local funding has had the most increase, albeit variable.

Form 4 - Children continue to be the primary target of services in the state. Screening programs, including school health services would be included in those costs. Many county health departments continue to assume school health services as part of their responsibilities, often without funding from the school district or reimbursement from insurance coverage's.The increase in infant and pregnant women expenditures may be in part attributed to the program income, much of which is for targeted case management for high risk pregnant women and infants. Variations between budgeted and expended amounts continue to vary by as much as 40% in some categories (pregnant women and others).

Form 5 - Direct expenditures reported by the counties continue to be high. This is in part due to definition and reporting issues. Large variations in expenditures by level of the pyramid continue. While definition issues continue to confound, a large percent of funding continues to support direct health care.

/2007/ Montana continues to experience decreases in MCHBG funding due to federal decreases and population shifts. Montana's block grant allocation has decreased by over $180,000 since 2001. County contracts, accounting for approximately 42% of the overall budget have decreased, as have state level program budgets. Cost allocation, or administrative costs, have increased. Counties have continued to overmatch the MCHBG, providing far more match than is required by contract.

Form 4 - Children's services continue to account for the largest portion of the federal/state/local MCH partnership. Counties commit over $2 million annually to services for children aged 1 - 22. Children with special health care needs have also received more resources from counties over the last year.//2007//

B. Budget

The proposed budget for FFY 2006 as outlined on Form 2 includes the following:

Primary and Preventive Services for Children $ 1,008,269

This budget item includes the budget for the state level Child, Adolescent and Community Health

Section and county level MCH anticipated to be spent for infants, children and others, including families.

Children with special health care needs $829,709
Primary and Preventive Services for Children $ 1,008,269

This budget item includes the budget for the state level Child, Adolescent and Community Health Section and county level MCH anticipated to be spent for infants, children and others, including families.

Children with special health care needs $829,709

Budget includes the CSHS budget of $764,000 plus $65,000 of cunty MCHBG which they report expending on the CSHCN population.

Title V Administrative Costs $224,404

Includes state indirects of $176,633 plus anticipated local of $47,777. Administrative rule allows counties to use up to 10% of their award for administrative costs. The state admin costs are increased by approximately $40,000, due in part to conversion of the BC position for "direct pay" to cost allocation.

Unobligated balance $0

Montana continues to budget and expend to the level of the annual award.

State MCH Funds $1,085,637

Budget includes public health home visiting general funds ($550,000) and funds to support the voluntary genetics program (apprximately $530,00).

Local MCH Funds $3,598,977

Local contractors continue to overmatch their contracted $1.1 million.

Program Income $791,235

County contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Cotnractor imposes any charges for services" under Section 1 of the MCH Services Task Order for Montana County Contracts.

Federal-State Block Grant Partnership $8,023,781

Other Federal Funds $18,334,262

/2007/

The proposed budget for FFY 2007 as outlined on Form 2 includes the following:

Primary and Preventive Services for Children $ 955,473

This budget item includes the budget for the state level Child, Adolescent and Community Health Section and county level MCH anticipated to be spent for infants, children and

others, including families. Decreased from last year due to decreased federal funding available.

Children with special health care needs $838,666

Slightly increased from last year due to county efforts.

Title V Administrative Costs $194,083

Includes state indirects and local administrative costs. Administrative rule allows counties to use up to 10% of their award for administrative costs.

Unobligated balance $0

Montana continues to budget and expend to the level of the annual award.

State MCH Funds $1,440,467

Budget includes public health home visiting general funds ($550,000), small amount of general funds to support MCH Administrative activities, and funds to support the voluntary genetics program (increased to approximately $850,000).

Local MCH Funds $3,165,000

Local contractors continue to overmatch their contracted receipts.

Program Income $743,094

County contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Cotnractor imposes any charges for services" under Section 1 of the MCH Services Task Order for Montana County Contracts.

Federal-State Block Grant Partnership $7,810,783

Other Federal Funds $19,458,492

Tables depicting the changes in Montana's Title V funding are attached. //2007//

An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.